Urogynecology
UNIVERSITY OF COLORADO

Welcome to the CU Urogynecology practice. We are happy that you chose our team to help you better understand and treat your pelvic floor symptoms. Cu Urogynecology provides a multidisciplinary pelvic health program, with urogynecology, colorectal, urology, and physical therapy experts working in partnership to cure interrelated pelvic floor disorders women face. Below you will find a compare symptoms and medical history questionnaire that will help us to make sure all your needs are met.

Name_____ **Date of Birth** _____ **Age** _____
Referring Doctor_____ **Primary Care Provider**_____
Gynecologist_____**Cardiologist**_____
Gastroenterologist_____

Reason(s) for visit (*check all that apply*):

☐ Dysuria (Burning with urination)
☐ Hematuria (blood in urine)
☐ Enuresis (bed wetting)
☐ Nocturia (nighttime frequency)
☐ Continuous leakage of urine
☐ Urinary retention
☐ Incomplete bladder emptying
☐ Recurrent UTI
☐ Urinary frequency
☐ Cystocele (bladder prolapse)
☐ Enterocele (bowl prolapse)
☐ Pelvic Organ Prolapse
☐ Uterine Prolapse
☐ Prolapse after Hysterectomy
☐ Urgency Incontinence
☐ Urinary Incontinence
☐ Stress Incontinence
☐ Mixed Incontinence
☐ Rectocele
☐ Intrinsic sphincter deficiency
☐ Chronic constipation
☐ Sling mesh erosion
☐ Vagina mesh erosion
☐ Problem from mesh
☐ Problem from sling
☐ Other: _____

How long have you had these symptoms?
☐ Less than 1 month ☐ 1 – 6 months ☐ 7 - 12 months ☐ Greater than a year ☐ 5 years or more

Please describe the severity of your symptoms since they began:
☐ Improving ☐ Stable ☐ Worsening

Urogenital History:
Do you have a history of the following? *(check all that apply and indicate year diagnosed)*

☐ Recurrent urinary tract infections (UTI) Year_____
☐ Pyelonephritis (kidney infections) Year_____
☐ Hematuria (blood in urine) Year_____
☐ Nephrolithiasis (kidney stones) Year_____
☐ Abnormal kidneys (one kidney, renal cysts, duplicated ureter) Year_____

How many UTIs have you had in the past year? ☐ 0 ☐ 1-2 ☐ 3 or more
If two or more, was a culture done to prove that an infection was present? ☐ Yes ☐ No

For the section below please check the box that best fits your symptoms and answer how much does it bother you:

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		Not Present	Not at All	Somewhat	Moderately	Quite a Bit
Prolapse Symptoms:		**No**	**Yes**			
		0	1	2	3	4
1	Do you usually experience pressure in the lower abdomen?	☐	☐	☐	☐	☐
2	Do you usually experience heaviness or dullness in the pelvic area?	☐	☐	☐	☐	☐
3	Do you **SEE** or **FEEL** a bulge in your vaginal area?	☐	☐	☐	☐	☐
4	Do you have to push on the bulge to help you urinate or around your rectum to have/complete a bowel movement?	☐	☐	☐	☐	☐
5	Do you usually experience a feeling of incomplete bladder emptying?	☐	☐	☐	☐	☐
6	Do you ever have to push a bulge in your vaginal area with fingers to start/complete urination?	☐	☐	☐	☐	☐

		Not Present	Not at All	Somewhat	Moderately	Quite a Bit
Colorectal Anal Distress Symptoms:		**No**	**Yes**			
		0	1	2	3	4
7	Do you feel you need to strain too hard to have bowel movement?	☐	☐	☐	☐	☐
8	Do you feel you haven't completely emptied bowels at the end of the bowel movement?	☐	☐	☐	☐	☐
9	Do you usually lose stool beyond your control if your stool is well formed?	☐	☐	☐	☐	☐
10	Do you usually lose stool beyond your control if your stool is loose?	☐	☐	☐	☐	☐
11	Do you usually lose gas from the rectum beyond your control?	☐	☐	☐	☐	☐
12	Do you usually have pain when you pass your stool?	☐	☐	☐	☐	☐
13	Do you experience a strong sense of urgency and must rush o the bathroom for a bowel movement?	☐	☐	☐	☐	☐
14	Does part of the bowl ever pass through the rectum and bulge outside during/after a bowel movement?	☐	☐	☐	☐	☐
15	How often do you have a bowel movement?	Time(s) a day			Times a week	

		Not Present	Not at All	Somewhat	Moderately	Quite a Bit
Pelvic Organ Prolapse Distress Inventory:		**No**	**Yes**			
		0	1	2	3	4

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16	Do you usually experience frequent urination?	☐	☐	☐	☐	☐
17	Do you usually experience urine leakage associated with the feeling of urgency?	☐	☐	☐	☐	☐
18	Do any of these activities cause you to leak? ☐ Coughing ☐ Sneezing ☐ Laughing ☐ Lifting heavy objects ☐ Exercise ☐ Movement	☐	☐	☐	☐	☐
19	Do you usually experience small amounts of urine leakage (that is, drops)?	☐	☐	☐	☐	☐
20	Do you usually experience difficulty emptying your bladder?	☐	☐	☐	☐	☐
21	Do you usually experience pain or discomfort in the lower abdomen or genital region?	☐	☐	☐	☐	☐
22	If you urinate, how long can you wait before you feel like you *must* urinate again?	Less than 30 minutes	30mins-1 hour	1-2 hours	2-3 hours	4 or more hours
23	How many times do you get up at night because you feel like you *must* urinate?	1 time	2-3 times	3-4 times	4 or more	None
24	How often do you have the inability to control urination?	Everyday/ every night	Few times a week	Few times a month	Less than once a month	Never
25	How much urine are you leaking?	None	Drops	Small Splash	More	
26	How often do you have the inability to control urination?	Everyday/ Every night	Few times a week	Few times a month	Less than once a month	Never
27	How much urine are you leaking?	None	Drops	Small Splash	More	
28	How often do you have an inability to control urination?	Everyday/ Every night	Few times a week	Few times a month	Less than once a month	Never
29	What forms of protection do you use to counter the leaking? (*check all that apply*) ☐ Incontinence pads ☐ Panty liners ☐ Absorbent underwear (Thinx) ☐ Not applicable ☐ Diapers ☐ Tissue paper ☐ None ☐ Other: _____ How many do you typically use? _____ Per Day OR _____ Per Week					

Interpersonal History:

Relationship status: (*check all that apply*)

☐ Married ☐ Not in a relationship ☐ Widowed
☐ Partner ☐ Divorced ☐ Other: _____

Are you currently sexually active? ☐ Yes ☐ No
If Yes, with whom? ☐ Male ☐ Female ☐ Both

Are you having any of the following sexual problems? (*check all that apply*):
☐ Pain with sex ☐ Incompatibility with partner ☐ Decreased/absent arousal ☐ Partner Sexual Dysfunction
☐ Low libido ☐ Vaginal Dryness ☐ Lack of orgasm
☐ Other: _____
Do you leak with vaginal penetration? ☐ Yes ☐ No
Do you leak when having an orgasm? ☐ Yes ☐ No

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CU also offers a Sexual Women's Health Clinic and we would be happy to refer you too if that is of interest. For more information on this clinic use the link: https://obgyn.coloradowomenshealth.com/services/clinics/womens-sexual-health-services

Dietary (Average cups/day):

Water	_____cups
Coffee	_____cups
Tea	_____cups
Soda/carbonated beverages	_____cups
Citric beverages	_____cups
Alcohol	_____drink(s)
Spicy Foods	_____times a week

We suggest going into MyChart to update your chart before you visit to ensure we have the most up to date information. This will give us the ability to focus more on your current symptoms rather than going back into your history. If you have updated your MyChart *it is not necessary to fill out the following boxed portion*. If you are a new patient or need to revise your history, please answer the boxed questions on pages 4-7 OR log into your MyChart. If you are a new patient visit this website to get started. https://www.uchealth.org/access-my-health-connection/

Medical History:

(Please check all conditions that apply to you)

☐ Arthritis
☐ Asthma/COPD
☐ Blood clots
☐ Blood Transfusion
☐ Connective Tissue Disorder
☐ Depression or Anxiety
☐ Diabetes
☐ DDD/ Spinal Stenosis
☐ Fibromyalgia
☐ GERD/ Reflux
☐ Heart Attack
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Inflammatory Bowel Disease
☐ Irritable Bowel Syndrome (IBS)
☐ Neurological Disease
☐ Stroke
☐ Thyroid Disease
☐ Cancer: (type _____)

Other conditions not listed or details from those checked off:

_____

_____

Allergies: ☐ **I have no known allergies to any medications, food, or materials**

Allergy	Reaction

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Medications: **(if you take more than four medications then please log on to my health connection to update the information)**
Please bring a list of your medication if you need more room

Medication	Dosage

Do you take aspirin, ibuprofen, coumadin or any other blood thinners on a regular basis? ☐ No ☐ Yes
If yes, what do you take: _____

Surgical History:
Have had any previous surgery for incontinence? (urine loss) ☐ No ☐ Yes Date: _____
If yes, type of surgery: _____

Have you had any previous surgery for pelvic relaxation/prolapse? ☐ No ☐ Yes Date: _____
If yes, type of surgery: _____

Have you had a hysterectomy? ☐ No ☐ Yes Date: _____
Type: ☐ Abdominal ☐ Vaginal ☐ Laparoscopic/Robotic
Ovaries: ☐ Were not removed ☐ One removed (☐L ☐R) ☐ Both removed

Have you had any other procedures on the urinary tract? (*check all that apply, list month/year*):
☐ Urethral dilation _____ ☐ Cystoscopy _____ ☐ Urodynamics (bladder testing) _____
☐ Urethral Bulking _____ ☐ Bladder distention_____ ☐ Bladder BOTOX _____

Have you had any other gynecologic (female) surgeries other than those you have already listed?
☐ No ☐Yes Date: _____
If yes, type of surgery: _____
If you have had prior prolapse or incontinence surgery please request that those records be sent to our office and bring copies of the operative notes if you don't have them please sign the attached release of records form so we can obtain them

Other Prior Surgeries: (Heart, gallbladder, appendix, D&C etc.) ☐No other surgeries

Date (month/year)	Surgical Procedure	Surgeon	Hospital

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Did you experience problems with anesthesia with any of these surgeries? ☐ No ☐ Yes

If yes, please describe what happened: _____

Family History of a pelvic floor disorder:

Do you have any family history of Incontinence or Pelvic organ prolapse? ☐ Yes ☐ No ☐ Unknown
If so, who in your family has or has had these symptoms? (*Check all that apply*)
☐ Mother ☐ Sibling ☐ Father ☐ Grandparent ☐ N/A

Health Habits:

Do you, or **have you ever** use/ed any of the following drugs? *(Check all that apply)*

☐ Heroin ☐ Methamphetamines ☐ Medical Marijuana ☐ Recreational Marijuana
☐ Cocaine ☐ IV (Intravenous)
☐ Tobacco: ☐ Former smoker ☐ Current sometimes ☐ Current everyday smoker

How often do you have a drink containing alcohol: ☐ Never ☐ Monthly or less ☐ 2-4 times a month
☐ 2-3 times a week ☐ 4 times or more a week

How many drinks a day/ week ☐ 1-2 ☐ 3-4 ☐ 5 or more ☐ None ☐Other: _____

Gynecologic History: Are you post- menopausal?

☐ No- if no please answer the following questions	☐ Yes-if yes please answer the following questions
What do you use to prevent pregnancy? ☐ Pill/Patch/Ring ☐ Depo-Provera ☐ IUD ☐ Barrier method ☐ Tubal Ligation ☐ Vasectomy Surgical Menopause? ☐ Hysterectomy ☐ Ovary removal ☐ Other:_____	Have you experienced any post-menopausal vaginal bleeding? ☐ Yes ☐ No What type of hormone are you taking? ☐ Estrogen ☐ Progesterone ☐ Testosterone ☐ Other: _____ Check any of the following hormones you are currently taking: ☐ Oral ☐ Patch ☐ Vaginal ☐ Sublingual ☐ Injectable

Lifestyle/ physical activity (per week):

What exercise activity do you do? (*Check all that apply*)

☐ Aerobic (jogging, walking) ☐ Flexibility (yoga, light stretches)

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☐ Strength (lifting weights, resistance machines) ☐ Balance (standing on one foot, heel-toe walking)

How many days do you exercise a week on average? _____ days

How many minutes do you exercise a week on average? _____ minutes

Do you have urine leakage when exercising? ☐ Yes ☐ No

Obstetric History:

Total number of times you have been pregnant: _____
How many vaginal deliveries have you had? _____
What was the weight of your largest baby vaginal delivery? _____lbs. _____oz.
How many c-sections have you had? _____
What was the weight of your largest baby through c section? _____lbs. _____oz.

Were forceps(metal spoons) used during delivery?	☐ Yes	☐ No	☐ I don't remember
Was a vacuum(suction) used during delivery?	☐ Yes	☐ No	☐ I don't remember
Did you have an episiotomy or any tares?	☐ Yes	☐ No	☐ I don't remember
If yes, was there any tearing in the anus or sphincter? (3rd or 4th degree)	☐ Yes	☐ No	
Desire for future fertility?	☐ Yes	☐ No	

Health maintenance:

When was your last pap smear (year/Date)? / /
- Pap smear findings? ☐ Normal ☐ Abnormal

If abnormal, what procedure was done?
☐ Colposcopy ☐ LEEP ☐ Cervical Biopsy ☐ Other: _____

When was your last mammogram (year/Date)? / /
- Mammogram findings? ☐ Normal ☐ Abnormal

When was your last colonoscopy (year/Date)? / /
- Colonoscopy findings? ☐ Normal ☐ Abnormal

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