UCSF Health

Patient Name:

Date of Birth:

Center for Pelvic Physiology
University of California, San Francisco Health at Mission Bay

1825 Fourth St, Fourth Floor
San Francisco, CA 94158
Office: 415-885-7673
Fax: 415-885-7678

Place Label Here

(office use only)

Demographic Information

Age: ______
Gender: ☐ Male ☐ Female ☐ Transgender
Race/Ethnicity *(check all that apply)*:
- ☐ White
- ☐ Black
- ☐ Asian
- ☐ Pacific Islander
- ☐ Latino/a
- ☐ Other: ____________________
- ☐ Mixed

Referring Physician ____________________________
Address ____________________________
____

Primary Care Physician ____________________________
Address ____________________________
____

Have you had this type of exam(s) before today? ☐ Yes ☐ No
If yes, when (Date)? ______________

Main Complaint:

____
____
____
____

SECTION 1 – GENERAL LIFESTYLE & BOWEL HABITS

Please check answer or write in the appropriate answers.

1. During a typical 2 week period, how many times do you usually have a bowel movement?
   - ☐1 1 or more times a day
   - ☐2 2 or fewer times per week
   - ☐3 Less than once per week
   - ☐4 Less than once per 2 weeks

2. Typically, how much time do you spend on the toilet trying to have a bowel movement?
   - ☐1 Less than 5 minutes
   - ☐2 5 to less than 10 minutes
   - ☐3 10 to less than 30 minutes
   - ☐4 30 minutes or greater

3. During the past 12 months, what does your bowel movement usually look like when you <u>are not</u> taking laxatives?

☐8 I don't know – I always use laxatives

☐1 Separate hard lumps, like nuts

☐2 Sausage-like but lumpy

☐3 Like a sausage but with cracks in the surface

☐4 Like a sausage or snake, smooth and soft

☐5 Soft blobs with clear-cut edges

☐6 Fluffy pieces with ragged edges, a mushy stool

☐7 Watery, no solid pieces

Additional information about your answers (Optional):

SECTION 2 - CONSTIPATION

Please fill out if constipation is your main complaint.

For each of the following questions please mark the one choice that best approximates your answer.

1a) How often do you experience incomplete bowel movements?

(0) Never (Skip to #2)	**(1) Occasionally**	**(2) Sometimes**	**(3) Usually**	**(4) Always**

1b) How severe is this symptom for you?

(1) Not at all severe *(Most of my bowel movement comes out)*	**(2) Mild**	**(3) Somewhat Severe** *(There is still a lot of stool in me after I have a bowel movement)*	**(4) Severe**	**(5) Extremely Severe** *(I feel constant pressure in my rectum from the stool or keep going back to the bathroom)*

1c) How much does this bother you?

(1) Not at all	**(2) A little**	**(3) Somewhat**	**(4) Very**	**(5) Extremely**

2a) How often do you experience straining/difficulty in having a bowel movement?

(0) Never (Skip to #3)	**(1) Occasionally**	**(2) Sometimes**	**(3) Usually**	**(4) Always**

2b) How severe is this for you?

(1) Not at all severe *(I push a little)*	**(2) Mild**	**(3) Somewhat Severe** *(I bear down hard)*	**(4) Severe**	**(5) Extremely Severe** *(I push on my belly, grunt and bear down very hard)*

2c) How much does this bother you?

(1) Not at all	**(2) A little**	**(3) Somewhat**	**(4) Very**	**(5) Extremely**

3) Think about when you ***ARE*** having difficulty with your bowel habits:
During a typical month, how many times do you ***usually*** have a bowel movement?
(Please check only one)

- ☐ 0 N/A – I never have difficulty with my bowel habits
- ☐ 1 Daily
- ☐ 2 A few times per week
- ☐ 3 Once per week
- ☐ 4 Once every 2 weeks
- ☐ 5 Once a month

4a) How often do you experience infrequent bowel movements (less than 1 bowel movement every 3 days)?

(0) Never (Skip to #5)	(1) Occasionally	(2) Sometimes	(3) Usually	(4) Always

4b) How severe is this symptom for you?

(1) Not at all severe *(I go almost everyday)*	(2) Mild	(3) Somewhat severe *(I go 1-2 times per week)*	(4) Severe	(5) Extremely severe *(I can go up to 4 weeks without going)*

4c) How much does this symptom bother you?

(1) Not at all	(2) A little	(3) Somewhat	(4) Very	(5) Extremely

5a) When you lack the urge to have a bowel movement, how severe is this for you?

(0) Never	(1) Not at all severe *(I have a pretty good sense when I have to go)*	(2) Mild	(3) Somewhat Severe *(I only have a vague sense that I might have to go)*	(4) Severe	(5) Extremely Severe *(I don,t have sensation in the pelvic area)*

5b) When you lack the urge to have a bowel movement, how much does this bother you?

(0) Never	(1) Not at all	(2) A little	(3) Somewhat	(4) Very	(5) Extremely

6) <u>During the last month</u>, on average, how severe was the pain in your rectum/anus?

(0) No pain	(1) Mild	(2) Somewhat severe	(3) Severe	(4) Extremely severe

7) Rate the level of your rectal/anal pain at the present moment.

(0) No pain	(1) Mild	(2) Somewhat severe	(3) Severe	(4) Extremely severe

8) How much suffering do you experience because of rectal/anal pain?

(0) None	(1) Mild	(2) Somewhat severe	(3) Severe	(4) Extremely severe

9) **During the past month**, due to your bowel habits, how often have you had bleeding during/after a bowel movement?

(0) Never	(1) Rarely	(2) Occasionally	(3) Usually	(4) Always

10. <u>During the past 12 months,</u> how often did you use medications or aids to have a bowel movement? Medications or aids are noted in bold type followed by examples of selected product names. (Please check one box in each row)

(Indicate product name used)	Never (0)	Less than Monthly (1)	Monthly (1-3 times a month) (2)	Weekly (1-6 times a week) (3)	Daily (4)	Has it helped? Yes No
1. Fiber: Metamucil Fibercon Benefiber Citrucel Flaxseed Konsyl	☐	☐		☐	☐	
2. Stool Softener: Colace Mineral Oil	☐	☐	☐	☐	☐	
3. Laxatives: ExLax Correctol Milk of Magnesia Dulcolax Lactulose Miralax Sorbitol	☐	☐	☐	☐	☐	
4. Other medications for constipation: Zelnorm Amitiza	☐	☐	☐	☐	☐	
5. Enemas: Fleets Colonics Tap water	☐	☐	☐	☐	☐	
6. Push on your belly to help evacuation	☐	☐	☐	☐	☐	
7. Finger in anus to help have a bowel movement	☐	☐	☐	☐	☐	
8. Exercise	☐	☐	☐	☐	☐	
9. Water	☐	☐	☐	☐	☐	
10. Caffeine	☐	☐	☐	☐	☐	
11. Artificial sweetener	☐	☐	☐	☐	☐	
8. Other aids: (list below) ____________ ____________ ____________	☐	☐	☐	☐	☐	

11. For how long have you been experiencing constipation or incomplete evacuation at least once per month?

☐ 1 0 to less than 12 months
☐ 2 1 to less than 5 years
☐ 3 5 to less than 10 years
☐ 4 10 to less than 20 years
☐ 5 20 years or more

SECTION 3 – FECAL INCONTINENCE

Please fill out if fecal incontinence is your main complaint.

For each of the following, please indicate on average how often in the past month you experienced any amount of accidental bowel leakage: (check only 1 box per row.)

	2 or more times a day (5)	**Once a day (4)**	**2 or more times a week (3)**	**Once a week (2)**	**1 to 3 times a month (1)**	**Never (0)**
a. Accidental leakage of gas	☐	☐	☐	☐	☐	☐
b. Accidental leakage of mucus (clear cloudy drainage)	☐	☐	☐	☐	☐	☐
c. Accidental leakage of liquid stool	☐	☐	☐	☐	☐	☐
d. Accidental leakage of solid stool	☐	☐	☐	☐	☐	☐

Do you…

	Yes	**No**
….usually experience a sense of urgency; that is, a strong sensation of needing to pass stool, and rush to the bathroom to have a bowel movement?	☐	☐
….leak gas or stool when you have urgency; that is, a strong sensation of needing to go to the bathroom?	☐	☐
….leak gas or stool when you sneeze, cough, exercise or during sexual activity?	☐	☐
….awake from sleep to have a bowel movement?	☐	☐
….have accidents while asleep?	☐	☐
…..have stains in your underwear?	☐	☐
…..use a pad in your underwear?	☐	☐
…..use disposable briefs/diaper in your underwear?	☐	☐
…use enemas to clean your bowels out?	☐	☐
…use medicine for diarrhea like Immodium or Lomotil?	☐	☐

SECTION 4: PELVIC FLOOR SYMPTOMS

URINARY INCONTINENCE: How often do you experience urinary leakage?

- ☐ $_0$ Never
- ☐ $_1$ Less than once a month
- ☐ $_2$ A few times a month
- ☐ $_3$ A few times a week
- ☐ $_4$ Everyday and/or night

How much urine do you lose each time?

- ☐ $_1$ Drops or little
- ☐ $_2$ More

Do you usually experience difficulty emptying your bladder?

- ☐ No
- ☐ Yes

If yes, how much does it bother you?

- ☐ Not at all
- ☐ Somewhat
- ☐ Moderately
- ☐ Quite a bit

SECTION 5: PAST MEDICAL HISTORY

	YES	NO
Have you ever been sexually assaulted or abused?		
If yes, did it involve vaginal penetration?		
Did it involve rectal penetration?		

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Dear Patient,

Welcome to the UCSF Center for Pelvic Physiology. Our goal is to provide a comprehensive evaluation of your pelvic problem. During your visit, we will review your medical history, your x-rays and reports and you will undergo a physical exam. Our health care team consists of medical students, nurses, nurse practitioners, and surgical residents under the supervision of your physician. Depending on the complexity of your problem, your visit may last several hours.

To prepare for your visit, please obtain copies of all reports relevant to your problem and bring them with you. Examples of reports would be colonoscopy, MRI, pathology, CT scans, laboratory blood tests, operation reports, hospital discharge summaries, and so on. If you have had any x-rays, have your hospital put the images on a CD-ROM (di-com format) and bring it to your visit.
We need to look at the images, not just the reports.

We strive to be detail-oriented and thorough. Your answers here will become part of the UCSF medical record and will be confidential.

Can you tell us the names of the doctor who referred you here, your primary care doctor, and any other doctor from whom you are receiving care?

Doctor who sent you to see us: ______________________________ City: ___________________

Primary care doctor: ______________________________________ City: ___________________

Additional doctor: ____ City: ___________________

Additional doctor: ____ City: ___________________

Additional doctor: ____ City: ___________________

What is the reason for your visit?

What is your occupation?

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ALLERGIC REACTIONS TO MEDICATIONS

Have you ever had a reaction to any of the following:

YES NO Latex
YES NO Iodine
YES NO Intravenous contrast agent (used in CT scans)

Are you allergic to any medications? If so, list the medication and the reaction that you had:

MEDICATION	REACTION (click all that apply)
Example: Aspirin	
	anaphylaxis/shock rash itching nausea/vomit short-of-breath other:
	anaphylaxis/shock rash itching nausea/vomit short-of-breath other:
	anaphylaxis/shock rash itching nausea/vomit short-of-breath other:
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PAST MEDICAL HISTORY

Please check any illnesses you have or had in the past: Provide detail here:

Illness	Detail
Seasonal allergies (hay fever)	
Anemia	
Anxiety	
Arthritis	
Asthma	
Bleeding disorders	
Blood disorder	
Blood transfusion in the past	
Cancer (list types)	
Congestive Heart Failure	
Clotting disorder	
Chronic bronchitis or emphysema	
Depression	
Diabetes mellitus	
Gastroesophageal reflux (heartburn)	
Glaucoma	
Heart disease	
HIV/AIDS	
Hypertension	
Intestinal disease	
Kidney disease	
Liver disease	
Myocardial infarction	
Nerve / muscle disease	
Osteoporosis	
Seizures	
Sinus disorder	
Skin disease	
Stroke	
Substance abuse	
Thyroid disease	
Ulcers	
OTHER:	

Have you ever been hospitalized? If yes, list the date(s) and reasons:

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PAST SURGICAL HISTORY

Please check any operations you have had: Year performed:

Operation	Year performed
Appendectomy	
Brain surgery	
Breast surgery	
Coronary artery bypass surgery	
Cholecystectomy (gallbladder removal)	
Colon surgery	
Cosmetic surgery	
Cesarian section	
Eye surgery	
Fracture surgery	
Hernia repair	
Hysterectomy (uterus removal)	
Joint replacement	
Prostate surgery	
Small intestine surgery	
Spine surgery	
Tubal ligation	
Valve replacement	
Vasectomy	

OTHERS:

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FAMILY HISTORY

Check the box if any relative of yours has / had one of these diseases:

Relationship	Name	Status	Colon Cancer	Rectal Cancer	Crohn's Disease	Breast Cancer	Uterine Cancer	Ovarian Cancer	Bladder Cancer	Prostate Cancer	Ulcerative Colitis
Mother											
Father											
Sister											
Brother											
Mat Aunt											
Mat Uncle											
Pat Aunt											
Pat Uncle											
Mat GM											
Mat GF											
Pat GM											
Pat GF											
OTHER											
OTHER											

HABITS

Do you drink alcohol? YES NO

If yes, what is your average number of:

	glasses of wine per week
	cans of beer per week
	shots of liquor per week

Do you use drugs recreationally now? YES NO

If yes, check the drugs you use:

amphetamines	amyl nitrate	anabolic steroid	barbituates	benzodiazepines
"crack" cocaine	cocaine	codeine	fentanyl	GHB
heroin	hydrocodone	hydromorphone	ketamine	LSD
marijuana	MDMA	methamphetamine	methaqualone	methylphenidate
morphine	nitrous oxide	opium	oxycontin	PCP
psilocybin	solvent inhalants	IV drugs	other:	other:

Are you a (mark one): current smoker former smoker never smoker passive smoker

How many packs per day do you smoke, on average?

How many years have you smoked?

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REVIEW OF SYMPTOMS

Have you experienced any of the following symptoms in the past 3 months?

			Symptom	Comments
GENERAL	YES	NO	fevers	
	YES	NO	chills	
	YES	NO	weight loss	
	YES	NO	malaise or fatigue	
	YES	NO	sweating	
	YES	NO	weakness	
SKIN	YES	NO	rash	
	YES	NO	itching	
HEAD	YES	NO	headaches	
	YES	NO	hearing loss	
	YES	NO	tinnitus	
	YES	NO	ear pain	
	YES	NO	ear discharge	
	YES	NO	nosebleeds	
	YES	NO	congestion	
	YES	NO	stridor (groan when you breathe)	
	YES	NO	sore throat	
EYES	YES	NO	blurred vision	
	YES	NO	double vision	
	YES	NO	irritation with lights (photophobia)	
	YES	NO	eye pain	
	YES	NO	eye discharge	
	YES	NO	eye redness	
CARDIOVASC	YES	NO	chest pain	
	YES	NO	palpitations (fluttering in the chest)	
	YES	NO	orthopnea (difficulty breathing while flat in bed)	
	YES	NO	claudication (pain in legs with exercise)	
	YES	NO	leg / ankle swelling	
	YES	NO	difficulty breathing during sleep	
LUNGS	YES	NO	cough	
	YES	NO	hemoptysis (coughing up blood)	
	YES	NO	sputum production (coughing up phlegm)	
	YES	NO	shortness of breath	
	YES	NO	wheezing	
ABDOMEN	YES	NO	heartburn	
	YES	NO	nausea	
	YES	NO	vomiting	
	YES	NO	abdominal pain	
	YES	NO	diarrhea	
	YES	NO	constipation	
	YES	NO	bright red blood in stool	
	YES	NO	melena (dark, tar like stools from old blood)	

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URINARY	YES	NO	dysuria (burning when you pee)
	YES	NO	urgency (need to pee quickly, can't barely hold it)
	YES	NO	frequency (need to pee often)
	YES	NO	hematuria (blood in the urine)
	YES	NO	flank pain
MUSCLES	YES	NO	myalgias (crampy muscle pain)
	YES	NO	neck pain
	YES	NO	back pain
	YES	NO	joint pain
	YES	NO	falls
BLOOD	YES	NO	easy bruising or easy bleeding
	YES	NO	seasonal allergies
	YES	NO	polydipsia (always thirsty)
NEURO	YES	NO	dizzyness
	YES	NO	tingling
	YES	NO	tremor
	YES	NO	sensory change
	YES	NO	speech change
	YES	NO	focal weakness
	YES	NO	seizures
	YES	NO	loss of consciousness
PSYCHIATRIC	YES	NO	depression
	YES	NO	suicidal ideas
	YES	NO	substance abuse
	YES	NO	hallucinations
	YES	NO	nervous / anxious
	YES	NO	insomnia
	YES	NO	memory loss

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Center for Pelvic Physiology

Diet / Bowel Movement Diary

Name:

Date of Birth:

Please complete prior to your first visit.

Monday
Breakfast ______________________________
Snack ______________________________
Lunch ______________________________
Dinner ______________________________

Time of Bowel Movement
____

Time spent sitting on the Commode
_______Minutes _______Hours

BM Description
Solid
Liquid
Formed

****

Tuesday
Breakfast ______________________________
Snack ______________________________
Lunch ______________________________
Dinner ______________________________

Time of Bowel Movement
____

Time spent sitting on the Commode
_______Minutes _______Hours

BM Description
Solid
Liquid
Formed

****

Wednesday
Breakfast ______________________________
Snack ______________________________
Lunch ______________________________
Dinner ______________________________

Time of Bowel Movement
____

Time spent sitting on the Commode
_______Minutes _______Hours

BM Description
Solid
Liquid
Formed

****

Thursday
Breakfast ______________________________
Snack ______________________________
Lunch ______________________________
Dinner ______________________________

Time of Bowel Movement
____

Time spent sitting on the Commode
_______Minutes _______Hours

BM Description
Solid
Liquid
Formed

****

Friday
Breakfast ______________________________
Snack ______________________________
Lunch ______________________________
Dinner ______________________________

Time of Bowel Movement
____

Time spent sitting on the Commode
_______Minutes _______Hours

BM Description
Solid
Liquid
Formed

****

Saturday
Breakfast ______________________________
Snack ______________________________
Lunch ______________________________
Dinner ______________________________

Time of Bowel Movement
____

Time spent sitting on the Commode
_______Minutes _______Hours

BM Description
Solid
Liquid
Formed

****

Sunday
Breakfast ______________________________
Snack ______________________________
Lunch ______________________________
Dinner ______________________________

Time of Bowel Movement
____

Time spent sitting on the Commode
_______Minutes _______Hours

BM Description
Solid
Liquid
Formed