UCSF Health
Women's Health

Patient Identification

NEW PATIENT QUESTIONNAIRE

Date: _____ Age:_____ Date of Birth: _____

Name: _____

Referring Doctor: _____

Primary Care Doctor: _____
(if different from referring doctor)

Please briefly summarize your health concern for today's visit.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What is the main goal of today's visit?

_____

_____

_____

How long have you had your most bothersome problem?

_____

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Pelvic Floor Distress Inventory – 20

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, how much they bother you. Answer these by putting an X in the appropriate box or boxes. While answering these questions, please consider your symptoms over the last 3 months.

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6) **Do you_____?**	**NO**	**YES**	**If YES, how much does it bother you?** **1 Not at all**	**2 Some what**	**3 Mod-erately**	**4 Quite a bit**
1. Usually experience pressure in the lower abdomen?	☐	☐	☐	☐	☐	☐
2. Usually experience heaviness or dullness in the pelvic area?	☐	☐	☐	☐	☐	☐
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	☐	☐	☐	☐	☐	☐
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	☐	☐	☐	☐	☐	☐
5. Usually experience a feeling of incomplete bladder emptying?	☐	☐	☐	☐	☐	☐
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	☐	☐	☐	☐	☐	☐
Colorectal-Anal Distress Inventory 8 (CRADI-8):						
7. Feel you need to strain too hard to have a bowel movement?	☐	☐	☐	☐	☐	☐
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	☐	☐	☐	☐	☐	☐
9. Usually lose stool beyond your control if your stool is well-formed?	☐	☐	☐	☐	☐	☐
10. Usually lose stool beyond your control if your stool is loose?	☐	☐	☐	☐	☐	☐
11. Usually lose gas from the rectum beyond your control?	☐	☐	☐	☐	☐	☐
12. Usually have pain when you pass your stool?	☐	☐	☐	☐	☐	☐
13. Experience a strong sense of urgency and have to rush to the bath-room to have a bowel movement?	☐	☐	☐	☐	☐	☐
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	☐	☐	☐	☐	☐	☐
Urinary Distress Inventory 6 (UDI-6):						
15. Usually experience frequent urination?	☐	☐	☐	☐	☐	☐
16. Usually experience urine leakage associated with a feeling of urgen-cy, that is, a strong sensation of needing to go to the bathroom?	☐	☐	☐	☐	☐	☐
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	☐	☐	☐	☐	☐	☐
18. Usually experience small amounts of urine leakage (that is, drops)?	☐	☐	☐	☐	☐	☐
19. Usually experience difficulty emptying your bladder?	☐	☐	☐	☐	☐	☐
20. Usually experience pain or discomfort in the lower abdomen or genital region?	☐	☐	☐	☐	☐	☐

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Part I: Urinary Stress Symptoms (MESA)	**0 Never**	**1 Rarely**	**2 Sometimes**	**3 Often**
(Would you say…)				
1. Does coughing gently cause you to lose urine?	☐	☐	☐	☐
2. Does coughing hard cause you to lose urine?	☐	☐	☐	☐
3. Does sneezing cause you to lose urine?	☐	☐	☐	☐
4. Does lifting things cause you to lose urine?	☐	☐	☐	☐
5. Does bending cause you to lose urine?	☐	☐	☐	☐
6. Does laughing cause you to lose urine?	☐	☐	☐	☐
7. Does walking briskly or jogging cause you to lose urine?	☐	☐	☐	☐
8. Does straining, if you are constipated, cause you to lose urine?	☐	☐	☐	☐
9. Does getting up from a sitting to a standing position cause you to lose urine?	☐	☐	☐	☐

Part II: Urinary Urge Symptoms (MESA)	**0 Never**	**1 Rarely**	**2 Sometimes**	**3 Often**
(Would you say…)				
1. Some women receive very little warning and suddenly find that they are losing, or are about to lose urine beyond their control. How often does this happen to you?	☐	☐	☐	☐
2. If you can't find a toilet or find that the toilet is occupied, and you have an urge to urinate, how often do you end up losing urine or wetting yourself?	☐	☐	☐	☐
3. Do you lose urine when you suddenly have the feeling that your bladder is very full?	☐	☐	☐	☐
4. Does washing your hands cause you to lose urine?	☐	☐	☐	☐
5. Does cold weather cause you to lose urine?	☐	☐	☐	☐
6. Do drinking cold beverages cause you to lose urine?	☐	☐	☐	☐

PGI-S	**1 Normal**	**2 Mild**	**3 Moderate**	**4 Severe**
Check the one number that best describes how your urinary tract condition is now:	☐	☐	☐	☐

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NEW PATIENT QUESTIONNAIRE

SECTION 1: URINARY SYMPTOMS

How often do you typically urinate during the day?

Every _____ hours, _____ # of times per day.

How often do you urinate during the night after going to bed? _____ # of times per night.

Do you TYPICALLY have pain or burning when you urinate? ☐ No ☐ Yes

Do you TYPICALLY have pain when your bladder is full? ☐ No ☐ Yes

If so, does the pain resolve when you empty? ☐ No ☐ Yes

Do you leak urine? ☐ No (Skip to Section 2) ☐ Yes

TYPICALLY, how many times do you leak urine during the daytime? (check one)

☐ Never ☐ _____ times per **(check one)** ☐ day / ☐ week / ☐ month

In the last month, how many times have you wet the bed at night?

☐ Never ☐ _____ times per **(check one)** ☐ day / ☐ week / ☐ month

Do you wear protection for urine loss? ☐ No **(skip to Section 2)** ☐ Yes

Use the following table to indicate how many of the following pads you use during day and night?

	Tissue	Mini-pad/liner	Regular pad	Heavy pad or diaper
DAYTIME	☐	☐	☐	☐
NIGHT TIME	☐	☐	☐	☐

When you change your pads, are they: ☐ Dry ☐ Have a few drops ☐ Wet ☐ Soaked

SECTION 2: BOWEL SYMPTOMS

How many bowel movements do you typically have each week? _____

Do you have trouble with bowel movements? Diarrhea? ☐ No ☐ Yes Constipation? ☐ No ☐ Yes

Do you have accidental bowel leakage? ☐ **No (skip to next section 3)** ☐ Yes

In a TYPICAL month, how often do you have accidental bowel leakage? #_____ times per month

Do you use pads or devices for bowel leakage? ☐ No ☐ Yes, #_____ per day

SECTION 3: TREATMENT HISTORY

Have you had prior treatment for PELVIC PROLAPSE, URINARY or BOWEL problems?

☐ **No (skip to Section 4)** ☐ Yes – use the table below to indicate which treatments you have tried.

Treatment	Tried	
Pelvic muscle exercises (Kegel or pelvic floor physical therapy)	☐ No ☐ Yes Did it help?	
Medications (Check one's you have tried)	☐ Darifenacin (Enablex)	☐ Oxybutynin (Ditropan or Ditropan XL, Oxytrol patch, gelnique)
	☐ Tolterodine (Detrol)	☐ Fesoterodine (Toviaz)
	☐ Solifenacin (Vesicare)	☐ Trospium (Sanctura)
	☐ Mirabegron (Myrbetriq)	☐ Other:_____
Reason for stopping	☐ Side Effects	☐ Didn't Help
Pessary or vaginal device	☐ No ☐ Yes Did it help?	

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SECTION 3: TREATMENT HISTORY *(Continued)*

	Date	Procedure
Pelvic floor surgery or procedure		

SECTION 4: OBSTETRIC AND GYNECOLOGIC HISTORY

No. of Pregnancies: _____ Vaginal deliveries: _____ Cesarean births: _____ Miscarriages or abortions: _____

If you have had a vaginal delivery:

- Please tell us the weight of your largest baby born vaginally: _____ pounds _____ounces
- Please indicate if you have ever had the following:
  - ☐ Forceps delivery ☐ Vacuum delivery
  - ☐ Severe tear after delivery that involved the anal sphincter/rectum

Check the category below to indicate when you went through menopause:

☐ Haven't yet gone through menopause ⇨	Are you using any form of contraception? ☐ No ☐ Yes: List: _____ Have you completed your family? ☐ No ☐ Yes ☐ Unsure
☐ Going through menopause now	☐ Yes ☐ Unsure
☐ I went through menopause at age ____ yrs ⇨	After menopause, did you use hormone replacement therapy? ☐ Never ☐ Past ☐ Current After menopause, did you use vaginal hormone therapy? ☐ Never ☐ Past ☐ Current

SECTION 5: SEXUAL FUNCTION

Pelvic floor problems often interfere with sexual relations. In order to best treat you, it is important to ask questions about your sexual health. If you feel uncomfortable answering these questions prior to your appointment, please discuss these issues with your provider at the time of your initial visit.

Is your sex life satisfactory for you?	☐ No ☐ Yes
Do you have any sexual concerns that you would like to address?	☐ No ☐ Yes
Are your sexual activities limited by your pelvic floor problem?	☐ No ☐ Yes
Are you sexually active at this time in your life?	☐ **No (skip to section 5)** ☐ Yes
Does your sexual activity include vaginal intercourse?	☐ No ☐ Yes
During intercourse, when do you leak urine?	☐ Never ☐ With penetration ☐ With orgasm
When do you have pain with intercourse?	☐ Never ☐ With deep penetration ☐ With entry

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SECTION 6: MEDICATIONS

Allergy to Medication :

☐ Yes (Please list below) ☐ **NO (Skip to Current**

List your medication allergies	Reaction

Current Medications:

Please list your CURRENT medications including supplements	Dose	Times per day	Approximate Start Date

SECTION 7: MEDICAL HISTORY – Please mark with an X if you have had any of the following medical conditions:

☐ Heart Disease
☐ Diabetes
☐ Anticoagulation therapy
☐ Neurologic disease
☐ Stomach Ulcer
☐ Cancer: Type:_____
☐ Heart attack
☐ Blood clots (deep venous thrombosis/) pulmonary embolism)
☐ Pelvic radiation
☐ Back injury
☐ Back pain or sciatica
☐ High blood pressure
☐ Recurrent uninary tract infections
☐ Glaucoma
☐ Hypothyroid
☐ Jehovah's witness/ refuse blood products

☐ Other medical problems: _____

SECTION 8: SURGICAL HISTORY – Please list ALL past surgeries

Date	Surgery	Comments

Please provide more details here if needed: _____

_____

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SECTION 9: FAMILY HISTORY

☐ No Family Medical History ☐ History unknown/Adopted

	High BP	Diabetes	Heart Attack	Stroke	Cancer	Incontinence	Prolapse
Father	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐
Daughter	☐	☐	☐	☐	☐	☐	☐
Son	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐

Please provide more details here if needed:

_____

_____

_____

SECTION 10: SOCIAL HISTORY

Tobacco Use: ☐ Never ☐ Current: Packs/day _____ ☐ Prior (quit): Quit date: _____

How many years did you smoke? _____

Smokeless Tobacco: ☐ Never ☐ Current ☐ Former

Alcohol Use: ☐ No ☐ Yes

If yes, what do you drink? _____ and how many ounces (oz.) per week? _____

SECTION 11: REVIEW OF SYSTEMS – Please check all that apply

Constitutional:	☐ Unusual fatigue	☐ Weight loss	☐ Loss of appetite
Eyes:	☐ Double vision	☐ Blurred vision	☐ Glasses/Contacts
Ears, Nose & Throat:	☐ Deafness	☐ Hoarseness	☐ Ringing in ears
Cardiac:	☐ Chest pain	☐ Irregular beats	☐ Palpitations
Pulmonary:	☐ Shortness of breath	☐ Chronic cough	☐ Wheezing
Gastrointestinal:	☐ Blood in stool	☐ Chronic diarrhea	☐ Black stools
Musculoskeletal:	☐ Pain in joints	☐ Lower back pain	☐ Muscle weakness
Skin:	☐ Bruising	☐ Hair loss	☐ Unexplained rash
Neurologic:	☐ Seizures	☐ Frequent Headaches	☐ Numbness
Psychiatric:	☐ Depressed	☐ Difficulty Sleeping	☐ Memory Loss
Endocrine:	☐ Hot flashes	☐ Dry skin	☐ Sensitive to heat/cold
Blood Diseases:	☐ Anemia	☐ Bleeding problem	☐ Enlarged lymph gland
Allergy:	☐ Sinus problems	☐ Allergic reaction	☐ Conjunctivitis

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URINARY DIARY

Patient Identification

PRIOR TO YOUR VISIT WITH US:

PLEASE COMPLETE THIS BLADDER DIARY IF YOU ARE SEEKING HELP FOR ANY OF THE FOLLOW URINARY PROBLEMS:

FREQUENCY, URGENCY, LEAKAGE (Incontinence) or WAKING AT NIGHT TO URINATE.

This diary is a record of your fluid intake, voiding (urinating), and incontinence (leakage of urine).

INSTRUCTIONS:

1. Choose a 24-hour period of time to keep this record. You will need to measure every void (urination) and the amount of all liquid you drink during those 24 hours.
2. Begin your record with the FIRST void when you arise from sleep (see the example below).
3. Use a standard 1 or 2 cup plastic measuring device and record in ounces or milliliters.
4. After voiding, you may discard that urine after you measure it (no need to collect the urine).
5. Record any leakage of urine and whether this was a small (1), moderate (2), or severe (3) leakage episode. Indicate whether you had an urge to urinate at the time of leakage.

Example:

TIME	Amount Voided	LEAK AMOUNT 1 – small 2 – moderate 3 – severe	ACTIVITY DURING LEAK	URGE PRESENT? Yes or No	FLUID INTAKE Amount and Type
6:45A	500 mL		Just awakened		
7:00A					6 ounces orange juice
8:45A		2	Turned on water		16 ounces coffee

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URINARY DIARY

Date: _____

Patient Identification

TIME	Amount Voided	LEAK AMOUNT 1 – small 2 – moderate 3 – severe	ACTIVITY DURING LEAK	URGE PRESENT? Yes or No	FLUID INTAKE Amount and Type

Made accessible 4/23