



## GYNECOLOGIC HISTORY

Menopause	Yes	No				
If No, last Menstrual Date: _____						
Endometriosis	Yes	No	Painful Periods	Yes	No	
Pelvic Pain	Yes	No	Painful Intercourse	Yes	No	
Prolapse	Yes	No	Fibroids	Yes	No	
Cysts	Yes	No	Pelvic Inflammatory Disease	Yes	No	
<b>Surgical Interventions:</b>			Urinary Tract Infection(s)	Yes	No	
Abdominal Surgery	Yes	No	Hernia repair	Yes	No	
Appendix	Yes	No	Gall Bladder	Yes	No	
Laparoscopy	Yes	No	Hemorrhoids	Yes	No	
Bladder Suspension	Yes	No	Hysterectomy	Yes	No	
Vaginal Repair	Yes	No	Other _____			

## OBSTETRIC History

Number of pregnancies \_\_\_\_\_ Number of Deliveries \_\_\_\_\_

Date of Delivery	Type of Delivery	Weight of Baby	Second Stage Duration/ Pushing	Episiotomy/ Tearing	Difficulty healing	Exercise after
1. _____						
2. _____						
3. _____						

## URINARY SYMPTOMS

Urge Incontinence	Yes	No	Stress Incontinence	Yes	No
Mixed Incontinence	Yes	No			
Difficulty making it to the toilet	Yes	No	Amount of warning before urination _____ minutes		
Accidents per day	____/day		Small _____ or Large _____		
Padding	Yes	No	Type of pads _____ # of pads/day _____		
Voiding Frequency	____/day		Painful urination	Yes	No
	____/night		Dribbling after urination	Yes	No
Trouble starting stream	Yes	No			

Please, **circle those activities** that provoke uncontrolled urination: cough/sneeze, laughing, Lifting, Active Exercise (running, jumping, etc), Minimal exercise (walking), sleeping, Nervousness/anxiety, sit to stand, leakage without specific cause, other \_\_\_\_\_

"Falling out" feeling	Yes	No		
Fluid Intake per day	____ glasses/day		How many are caffeinated? _____/day	
Bowel Incontinence	Yes	No	Frequency _____/day or week	

## MEDICATION

Aspirin	Yes	No	Tylenol/acetaminophen	Yes	No
Advil/Motrin/Ibuprofen	Yes	No	Laxatives	Yes	No
Pain Relievers (Vicodin, Percocet)	Yes	No	Muscle Relaxants (valium)	Yes	No
Birth Control Pills	Yes	No	Hormone Replacement (Estrogen/progesterone)	Yes	No
Water Pills (diuretics, Laxix)		Yes	No Antibiotics		Yes
Decongestants/antihistamines (Codeine, Ephedrine)	Yes	No	Antidepressant Medication (Lexipro, Prozac)	Yes	No
Vitamins/Supplements/Herbals	Yes	No	Stomach/ulcer Medication	Yes	No
High blood Pressure Medication (Lopressor)	Yes	No	Cholesterol Medication (Lipitor, Zocor)	Yes	No
Other _____					