Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

CLINIC • PELVIC HEALTH CENTER • NEW PATIENT QUESTIONNAIRE

PELVIC HEALTH NEW PATIENT FORM

Please list the problems you would like evaluated today: *(circle what bothers you most)*

_____

_____

How long have you had *THIS* problem? _____

Have you been evaluated for *THIS* problem before today's visit? ❑ No ❑ Yes

If yes, check all that apply ❑ Colorectal Surgeon ❑ Gastroenterologist ❑ Urogynecologist

❑ Urologist ❑ Pelvic Floor Physical Therapist ❑ Other specialist(s): _____

PREVIOUS DIAGNOSTIC STUDIES *(Please check all applicable boxes)*

❑ **CT Scan**	❑ **Anorectal manometry**	❑ **Cystoscopy** (look in bladder with scope)
❑ **Kidney Ultrasound**	❑ **Barium enema**	❑ **Urodynamic test** (bladder function test with catheter)
❑ **Pelvic Ultrasound**	❑ **Colonoscopy**	❑ **Other:**
❑ **MRI**	❑ **Defecography**	

PAST MEDICAL HISTORY *(Please check all that apply, now or in the past)*

❑ **I have no medical problems** ❑ **I reviewed list on MyHealth**

❑ **Anxiety**	❑ **Dementia (i.e. Alzheimer's)**	❑ **Kidney Failure**
❑ **Asthma**	❑ **Diabetes, *type:*** _____	❑ **Kidney stones**
❑ **Blood Clots**	❑ **Gastrointestinal Ulcers**	❑ **Liver Disease/Hepatitis**
❑ **Cancer:** _____	❑ **Heart Attack/Chest Pain**	❑ **Psychiatric Disease**
❑ **COPD**	❑ **Heart Valve/Rhythm Problem**	❑ **Stroke/TIA**
❑ **Chronic back pain +/- Neuropathy**	❑ **Immune Disorder** *(specify)*: _____	❑ **Neurologic Disease:** *(specify)*: _____
❑ **Depression**	❑ **High Blood Pressure**	❑ **Thyroid Disease**

❑ **Other significant medical problems, hospitalizations, or trauma** *(specify)*: _____

_____

LIST CURRENT MEDICATIONS (*Attach list if available*)

❑ No Medications ❑ I reviewed my medication list on MyHealth/medical chart, I have no updates

MEDICATION ALLERGIES *(Please list below)* ❑ None ❑ I reviewed list on MyHealth/medical chart

SURGICAL HISTORY ❑ I have had no surgeries ❑ I reviewed list on MyHealth/medical chart

Operation **Month/Year** **Reason for Surgery**

FAMILY HISTORY **(i.e. Cancer, Frequent UTIs, Kidney Stones, Prolapse, Heart Attack before age 60)**

❑ I have no family history of medical problems

SOCIAL HISTORY

Do you use any tobacco? (*Check all that apply*)

❑ Never smoked

❑ No, I quit When? _____ #packs/day? _____ How many years (estimate)? _____

❑ Yes, I smoke tobacco_____ #packs/day? _____ How many years (estimate)? _____

Do you drink alcohol? ❑ Yes ❑ No *If yes, how many drinks per week/month/year*? _____

Do you use recreational drugs? (i.e. marijuana, cocaine, heroin, methamphetamines, etc.)

❑ Yes ❑ No *If yes*: What type? _____ How often? _____

MARITAL STATUS: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other _____

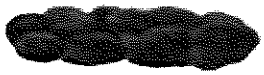
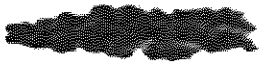
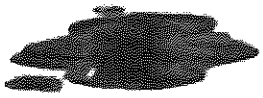
OCCUPATION: _____

Have you ever been sexually abused, threatened, or hurt by anyone?

❑ Yes, in the past ❑ Yes, currently ❑ No

GASTROINTESTINAL HISTORY

During the past 12 months, what do your bowel movements usually look like *when you are not taking laxatives*? (**please circle**)

BRISTOL STOOL CHART		
Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

During a typical 2-week period, how many times do you usually have a bowel movement?

_____ 1 or more/day

_____ 1-3 times/week

_____ Less than once/week

_____ Less than once/2 weeks

Please complete if you have any BOWEL PROBLEMS (*Otherwise, skip to **next page***)

Accidental Bowel Leakage (Fecal Incontinence): Unable to control the bowel

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

	Never	Less than once a month	Greater than once a month and less than once a week	Greater than once a week and less than daily	Daily or several times a day
Gas					
Liquid Stool					
Solid Stool					
Do you wear a pad?					
Does bowel leakage impact your quality of life?					

Difficult Evacuation: Difficulty emptying the bowels

Do you have difficulty emptying the bowels? (*Check only 1 box per row*)

	Never	Rarely	Sometimes	Usually	Always
Excessive Straining					
Incomplete rectal sensation					
Use of enema/laxatives					
Do you need to use a finger to help evacuate stool					
Abdominal discomfort /pain					

Do you have rectal bleeding? ❑ Yes ❑ No

Do you have rectal pain? ❑ Yes ❑ No

Do you have rectal mucus discharge? ❑ Yes ❑ No

Please complete if you have any URINARY PROBLEMS *(Otherwise, skip to the **next section**)*

Do you take <u>any medications</u> for an overactive bladder? ❑ Yes ❑ Yes, but I stopped taking it ❑ No

***<u>CIRCLE</u>** all that apply:* Oxybutynin, Trospium, Detrol, Vesicare, Mirabegron, Enablex, Toviaz

Other: _____

On average, over the past 4 weeks….		**How much does this bother you?** 0 = not at all 10 = a great deal
1. How often do you pass urine during the day?	❑ 1-6 0 ❑ 9-10 2 ❑ 7-8 1 ❑ 11-12 3 ❑ 13 or more 4	0 1 2 3 4 5 6 7 8 9 10
2. During the night, how many times do you have to get up to urinate, on average?	❑ none 0 ❑ three 3 ❑ one 1 ❑ four or more 4 ❑ two 2	0 1 2 3 4 5 6 7 8 9 10
3. Do you rush to the toilet to urinate?	❑ never 0 ❑ most of the time 3 ❑ occasionally 1 ❑ all of the time 4 ❑ sometimes 2	0 1 2 3 4 5 6 7 8 9 10
4. Does urine leak before you can get to the toilet?	❑ never 0 ❑ most of the time 3 ❑ occasionally 1 ❑ all of the time 4 ❑ sometimes 2	0 1 2 3 4 5 6 7 8 9 10
5. How often do you leak urine?	❑ never 0 ❑ about once per day 3 ❑ about once a week or less 1 ❑ several times a day 4 ❑ 2 or 3 times a week 2 ❑ all the time 5	
6. How much urine do you *<u>usually</u>* leak?	❑ none 0 ❑ a moderate amount 4 ❑ a small amount 2 ❑ a large amount 6	
7. Overall, how much does leaking urine interfere with your everyday life?	**Not at all** 0 1 2 3 4 5 6 7 8 9 10 **A great deal**	

8. *When* does urine leak? *(Please check all that apply)* and ***indicate how often*** *(circle one)*

❑ **Never** – urine does not leak	--	--	--	--
❑ leaks **before** you can get to the toilet	**rarely**	**daily**	**weekly**	**monthly**
❑ leaks when you **cough or sneeze**	**rarely**	**daily**	**weekly**	**monthly**
❑ leak when you are **physically active/exercising**	**rarely**	**daily**	**weekly**	**monthly**
❑ leaks when you are **asleep**	**rarely**	**daily**	**weekly**	**monthly**
❑ leaks when you have **finished urinating and are dressed**	**rarely**	**daily**	**weekly**	**monthly**
❑ leaks for **no obvious reason** (unaware of when leaking occurs)	**rarely**	**daily**	**weekly**	**monthly**
❑ leaks **all the time**	--	--	--	--

ICIQ – OAB (sum scores of 1+2+3+4) and ICIQ-UI (sum scores of 5+6+7)

Do you wear protection for urinary leakage? If so, how many do you wear per day?

❑ none ❑ pantyliners _____ ❑ pads _____ ❑ diapers _____

❑ I change my clothing ❑ other _____

Do you have difficulty emptying your bladder? ❑ **Yes** ❑ **No** ❑ **Sometimes**

If yes, *please check all that apply:*

❑ I feel that my bladder never or rarely gets empty
❑ It takes a while to get started
❑ I drip after I am finished urinating and walk away
❑ My stream is stop and go
❑ I have to go back to the bathroom right after urinating
❑ I have a weak stream most of the time
❑ I've had a catheter before because I couldn't urinate
❑ I always have to strain to urinate
❑ I had surgery to treat a urethral stricture (i.e. dilation, laser etc.) _____

Do you drink any of the following fluids? *Please check all that apply and give your best estimate*

❑ Caffeine (i.e. coffee, tea, soda, energy drinks) How many cups/day: _____
❑ Carbonated fluids (i.e. sparkling water, caffeine free soda) How many cups/day: _____
❑ Water (uncarbonated) How many cups/day: _____
❑ Other (please list): _____ How many cups/day: _____

Do you have any of the following? *If yes, please check all that apply*

❑ Burning with urination ❑ Visible blood in urine ❑ No, I do not experience any of these

Do you have *Recurrent Urinary Tract Infections* (UTIs)? ❑ Yes ❑ No

If yes, please answer the following questions, otherwise skip to the next page

How *OFTEN* do you get UTIs (how many per year)? _____

How long has this been a problem (how many months or years)? _____

Please check all that apply:

❑ I always get urine cultures, they are usually positive
❑ I get urine cultures sometimes
❑ I always get urine cultures, they are usually negative
❑ I just get antibiotics when I have UTI

What are your UTI symptoms (please list all)? _____

What are your UTI triggers (i.e. sexual activity)? _____

What makes your UTIs better? _____

GYNECOLOGICAL HISTORY

Please complete if you are FEMALE (*Otherwise, skip to **next page***)

Number of pregnancies _____ Number of vaginal deliveries _____ Number of C-sections _____

Were forceps or a vacuum used for any of your deliveries? ❑ Yes ❑ No ❑ Not applicable

When was your last menstrual period (or age at your last period)? _____

Note: If you are post-menopause or hysterectomy (uterus removed), please give estimated age at last menstrual period.

Are your periods regular? ❑ Yes ❑ No ☐ Not applicable (i.e. menopause, hysterectomy)

Have you had a Pap smear?

❑ Yes, all tests have been negative ❑ Yes, I have had abnormal test(s) ❑ No, never

If yes, when was your last Pap smear (year)? _____

	Yes	No	Sometimes	Sometimes, but it doesn't bother me	N/A
Are you sexually active?					
Do you have pain with sex?					
Do you have abnormal vaginal bleeding? (Bleeding between periods or after menopause)					
Do you feel a bulge or pressure in the vagina?					

Are you currently on any of the following? ❑ No ❑ Yes (*If yes, please check all that apply)*

❑ Cranberry pills
❑ Low dose antibiotics
❑ Probiotics
❑ D-mannose powder
❑ Birth control pills/patch/ring/shots
❑ Intrauterine Device (IUD) (i.e. Copper, Mirena)
❑ Topical Vaginal estrogen (i.e. Estrace, Premarin, Vagifem, Estring)
❑ Hormone replacement pills/patch/gel (i.e. estrogen, progesterone)

Have you had any of the following therapies?

❑ Pelvic Floor PT
❑ Pessary
❑ Urinary incontinence surgery
❑ Pelvic Organ Prolapse surgery
❑ Hysterectomy (uterus removed)
❑ Oophorectomy (ovaries removed)

Please complete if you are **MALE** (*Otherwise, skip to **Current Review of Systems)***

1. **Do you have problems with erections?** ❑ Yes ❑ No
   If yes, have you tried medications in the past? ❑ Yes ❑ No ❑ No, but I would like to try one

2. **Do you take any of the following medications?** ❑ No ❑ Yes ❑ Yes, but I stopped taking it
   If yes, *please check all that apply*

   ❑ Tamsulosin (Flomax)
   ❑ Alfuzosin (Uroxatral)
   ❑ Terazosin (Hytrin)
   ❑ Doxazosin(Cardura)
   ❑ Sildosin (Rapaflo)
   ❑ Dutasteride (Avodart)
   ❑ Proscar (Finasteride)
   ❑ Dutasteride/Tamsulosin (Jalyn)
   ❑ Testosterone replacement therapy
   ❑ Other prostate/male health medications: _____
   ❑ Viagra
   ❑ Cialis
   ❑ Levitra
   ❑ Staxyn

3. **Have you had a Prostate Specific Antigen (PSA) – prostate cancer screening test?**
   ❑ Yes, all have been normal ❑ Yes, they have been elevated ❑ No, never
   If yes, what was your last score (estimate is okay)? _____ (month/year) _____

4. **Do any of the following apply to you?** ❑ No ❑ Yes (*If yes, please check all that apply)*
   ❑ I had surgery to treat an enlarged prostate (i.e. TURP- Transurethral resection of prostate)
   ❑ I had a prostate biopsy in the past
   ❑ I have a family history of prostate cancer
   ❑ I have a personal history of prostate cancer (*If yes, what treatment did you receive*? _____)

Please complete if you are **MALE** (*Otherwise, skip to **Current Review of Systems)***

Over the past month or so, HOW OFTEN HAVE YOU HAD THE FOLLOWING: (Circle One Number on Each Line)	Not at All	Less Than 1 Time in 5 (<20%)	Less Than Half the Time (<50%)	About Half the Time (~50%)	More than Half the Time (>50%)	Almost Always
A sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Stopped and started again several times when you urinated?	0	1	2	3	4	5
Found it difficult to postpone urination?	0	1	2	3	4	5
A weak urinary stream?	0	1	2	3	4	5
Had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 or More
How many times per night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add the score for each number above: TOTAL: _____

Symptom score: 1-7 = mild 8-19 = moderate 20-35 = severe

0=Delighted 1=Pleased 2=Mostly Satisfied 3=Mixed 4=Mostly Not Satisfied 5=Unhappy

How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5

CURRENT REVIEW OF SYSTEMS

Have you had any problems **in this past year**? Check Yes or No and *explain Yes answers*.

(Patients will be writing their comments on the form)

		PATIENT COMMENTS
Allergic/Immunologic (rashes/infections/etc)	❑ Yes ❑ No	
Constitutional (general health, weight, energy)	❑ Yes ❑ No	
Cardiovascular (heart/blood vessels/circulation)	❑ Yes ❑ No	
Eyes (any visual problems)	❑ Yes ❑ No	
Ears/Nose/Mouth/Throat (hearing/infections/congestion/pain)	❑ Yes ❑ No	
Endocrine (hormones/metabolism/thyroid)	❑ Yes ❑ No	
Gastrointestinal (stomach/intestines/bowel movements)	❑ Yes ❑ No	
Hematologic/Lymphatic (bleeding/lymph nodes/swollen glands)	❑ Yes ❑ No	
Musculoskeletal (bones/joints/muscles)	❑ Yes ❑ No	
Neurological (brain/nervous system)	❑ Yes ❑ No	
Psychiatric (emotions/mood/memory)	❑ Yes ❑ No	
Respiratory (lungs/breathing)	❑ Yes ❑ No	
Integumentary (skin lesions/breast lumps)	❑ Yes ❑ No	
Genitourinary (genitals/sexual function/kidneys/bladder)	❑ Yes ❑ No	

By signing below, you are verifying that this form was completed to the best of your ability and knowledge.

DATE _____ TIME _____ SIGNATURE (Patient /Legal Designated Representative) _____

PRINT NAME _____ RELATIONSHIP TO PATIENT _____

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PROVIDER DOCUMENTATION

Instructions to Attending Physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note, however, the questionnaire may be referenced for additional details.

Attending Physician Signature	Print Name	Date	Time

The preceding information was also reviewed by:

Date	Time	Provider Signature/Title	Print Name

Date	Time	Provider Signature/Title	Print Name

Date	Time	Provider Signature/Title	Print Name

Copy: Patient ☐ Declined ☐ Received