MEDICATIONS/SUPPLEMENTS LIST

NAME	MG, IU, ETC.	TIMES/DAY

ADVANCED PELVIC SURGERY, LLC 7162 Liberty Centre Dr., Ste. B, West Chester, OH 45069 (513) 942-7640

New Patient Consult HPI (PLEASE PRINT) **Date of visit**_____

Name_____ DOB _____ Age _____

Referring Doctor _____ Primary Doctor _____

What is the main reason for your visit? _____
How long have you had the problem? _____

What makes it better or worse? _____

Please list all your bladder, bowel or GYN surgeries_____

_____

Do you have urine loss with coughing or activity? [Yes] [No] With the urge to void? [Yes] [No] Do you have urinary urgency without leaking? [Yes] [No]

How many times a day? _____ Do you need pads? [Yes] [No] How many a day? _____

Do you have problems starting your urine stream? [Yes] [No] Slow stream? [Yes] [No] Emptying your bladder [Yes] [No] Dribbling? [Yes] [No]

How long can you go between urinations during the day? _____How many times do you void at night? _____
Do you wet the bed? [Yes] [No]

When was your last urinary tract infection? _____ Have you ever had kidney stones or blood in your urine? [Yes] [No] If so, what was done to treat it? _____

How often do you move your bowels? _____Do you have trouble moving your bowels? [Yes] [No]
If so what is the trouble? _____

Do you have problems controlling gas? [Yes] [No] Liquid Stool? [Yes] [No} Solid stool? [Yes] [No] If so, how often do you have accidents? _____ Do you need pads for stool incontinence? [Yes] [No]

Do you feel like your bladder, uterus or rectum has fallen? [Yes] [No] Does this affect intercourse? [Yes] [No] Is there tissue at or outside the vaginal opening? [Yes] [No]

How many Pregnancies? _____ How many children? _____ How many vaginal deliveries? _____
How many C-Sections? _____What difficulties did you have with labor and delivery? _____

When was you last period? _____What birth control do you use? _____

PREVENTIVE HEALTH MAINTENANCE:

When was your last? PAP/Annual _____ Normal/Abnormal Dexa Scan _____ Normal/Abnormal

Mammogram _____ Normal/Abnormal Colonoscopy _____Normal/Abnormal

Any Abnormal results/ Treatment Plans? _____

_____

_____

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New Patient Consult **Date of visit**_____

DRUG ALLERGY	REACTION

Medical Problems_____

_____

_____

_____

Surgeries/Year Performed _____

_____

_____

Serious medical problems in your family_____

_____

Social History

Have you ever smoked? _____ How long? _____ Do you smoke currently_____ Packs/day _____

How often and how much do you drink? _____

Marital status? _____

Are you sexually active? _____ Any problems? _____

What is your occupation? _____

Are you depressed or do you have a history of depression? _____

Pharmacy:

NAME _____**STREET/CITY/CTATE/ZIP CODE** _____

PHARMACY PHONE NUMBER _____

Name _____ **Date** _____

REVIEW OF SYSTEMS

Have you had any problems related to the following in the past 6 months?

Circle Yes or No:

General:

Fever	Y	N
Weight change	Y	N
Tire Easily	Y	N

Eyes:

Change in vision	Y	N
Cataracts	Y	N
Glaucoma	Y	N

Ears, Nose, Throat:

Sores	Y	N
Discharge	Y	N
Pain	Y	N

Respiratory:

Chronic Cough	Y	N
Asthma	Y	N
COPD	Y	N

Cardiovascular:

Shortness of breath	Y	N
Chest Pain	Y	N

Gastrointestinal:

Nausea/vomiting	Y	N
Reflux	Y	N
Diarrhea	Y	N
Bloody Stool	Y	N

Skin/Breast:

Breast Lumps	Y	N
Skin Rash	Y	N

Musculoskeletal:

Weakness	Y	N
Limited range of motion	Y	N
Joint Pain	Y	N

Neurological:

Seizures	Y	N
Burning or shooting pain	Y	N
Numbness	Y	N

Hematological:

Easy bruising	Y	N
Bleeding	Y	N
Swollen Glands	Y	N

Endocrine:

Thyroid problems	Y	N
Diabetes	Y	N

Psychiatric:

Depression	Y	N
Anxiety	Y	N

Please list details associated with any of the above _____

_____

Name:_____ Date:_____

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Quality of Life

Date of visit_____

Has urine leakage and or prolapse affected your:	None	Slightly	Moderately	Greatly
Ability to do household chores?	0	1	2	3
Physical recreation such as walking?	0	1	2	3
Swimming or exercise?	0	1	2	3
Entertainment activities (movies, concerts, etc.)?	0	1	2	3
Ability to travel by car or bus more than 30 minutes?	0	1	2	3
Participation in social activities outside the home?	0	1	2	3
Emotional health (nervousness, depression, etc)?	0	1	2	3
Feeling frustrated?	0	1	2	3
Do you experience, and, if so, how much are you bothered by:				
Frequent urination?	0	1	2	3
Urine leakage related to the feeling of urgency?	0	1	2	3
Urine leakage related to physical activity, coughing, or sneezing?	0	1	2	3
Small amounts of urine leakage (drops)?	0	1	2	3
Difficulty emptying your bladder?	0	1	2	3
Pain or discomfort in the lower abdomen or genital area?	0	1	2	3

Name _____ Date _____

Your Daily Bladder Diary

This diary will help you and your health care team figure out the causes of your bladder control trouble.
The "sample" line shows you how to use the diary.

Time	Drinks		Trips to the Bathroom		Accidental Leaks	Did you feel a strong urge to go?	What were you doing at the time?
	What kind?	How much? oz, mL, cups	How many times?	How much urine?	How much urine?		Sneezing, [illegible] sleeping, etc.
Sample	Juice	8 ounces	✓✓	(sm) med lg	(sm) med lg	(Yes) No	Running
6–7 a.m.				○ ○ ○	○ ○ ○	Yes No	
7–8 a.m.				○ ○ ○	○ ○ ○	Yes No	
8–9 a.m.				○ ○ ○	○ ○ ○	Yes No	
9–10 a.m.				○ ○ ○	○ ○ ○	Yes No	
10–11 a.m.				○ ○ ○	○ ○ ○	Yes No	
11–12 noon				○ ○ ○	○ ○ ○	Yes No	
12–1 p.m.				○ ○ ○	○ ○ ○	Yes No	
1–2 p.m.				○ ○ ○	○ ○ ○	Yes No	
2–3 p.m.				○ ○ ○	○ ○ ○	Yes No	
3–4 p.m.				○ ○ ○	○ ○ ○	Yes No	
4–5 p.m.				○ ○ ○	○ ○ ○	Yes No	
5–6 p.m.				○ ○ ○	○ ○ ○	Yes No	
6–7 p.m.				○ ○ ○	○ ○ ○	Yes No	
7–8 p.m.				○ ○ ○	○ ○ ○	Yes No	
8–9 p.m.				○ ○ ○	○ ○ ○	Yes No	
9–10 p.m.				○ ○ ○	○ ○ ○	Yes No	
10–11 p.m.				○ ○ ○	○ ○ ○	Yes No	
11–12 mid.				○ ○ ○	○ ○ ○	Yes No	
12–1 a.m.				○ ○ ○	○ ○ ○	Yes No	
1–2 a.m.				○ ○ ○	○ ○ ○	Yes No	
2–3 a.m.				○ ○ ○	○ ○ ○	Yes No	
3–4 a.m.				○ ○ ○	○ ○ ○	Yes No	
4–5 a.m.				○ ○ ○	○ ○ ○	Yes No	
5–6 a.m.				○ ○ ○	○ ○ ○	Yes No	

Use this sheet as a master for making copies that you can use as a bladder diary for as many days as you need.

I used ______ pads today. I used ______ diapers today (write number).

Questions to ask my health care team: