GRANGER MEDICAL CLINIC

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New Patient Health History Form

Patient Name: _____ DOB: _____ Age: _____
Phone #: _____ Email: _____

Why are you seeing urogynecology? _____
_____

Prolapse

Do you feel tissue protruding out the vagina? ☐ Yes ☐ No Do you feel pressure in the pelvis? ☐ Yes ☐ No
If yes to either, what is the impact to your quality of life? ☐ Minimal ☐ Moderate ☐ Severe

Urge Incontinence

Do you get strong urges to urinate? ☐ Yes ☐ No If yes, how often? ☐ Occasionally ☐ Weekly ☐ Daily
Do you leak with these urges? ☐ Yes ☐ No If yes, how much do you leak? ☐ Drops ☐ More ☐ Soak
What is the impact to your quality of life? ☐ Minimal ☐ Moderate ☐ Severe

Stress Incontinence

Do you leak with cough, sneeze, or exercise? ☐ Yes ☐ No If yes, how often? ☐ Occasionally ☐ Weekly ☐ Daily
If yes, how much do you leak? ☐ Drops ☐ More ☐ Soak
What is the impact to your quality of life? ☐ Minimal ☐ Moderate ☐ Severe
Do you wear a pad? ☐ Yes ☐ No If yes, which type? ☐ Light ☐ Large ☐ Depends
How often do you urinate during the daytime? ☐ Every few hours ☐ More often ☐ Less often
How much do you urinate during the night? _____

Urinating

Any difficulty starting urination? ☐ Yes ☐ No Do you experience weak or intermittent stream? ☐ Yes ☐ No
Are you able to empty? ☐ Yes ☐ No Any pain or burning with urination? ☐ Yes ☐ No
Any recurrent UTIs? ☐ Yes ☐ No

Intake

How many caffeinated beverages do you drink per day?_____ How many glasses of fluid (total intake) per day? _____

GI

Any constipation? ☐ Yes ☐ No Frequency of Stools: ☐ Daily ☐ Less often ☐ More often
Consistency of Stools: ☐ Normal ☐ Loose ☐ Hard ☐ Both Do you strain for stools? ☐ Yes ☐ No
Do you experience fecal incontinence? ☐ Yes ☐ No If yes, how often? ☐ Occasionally ☐ Weekly ☐ Daily
If yes, do you leak? ☐ Gas ☐ Liquid ☐ Solid Do you experience fecal urgency? ☐ Yes ☐ No
Do you experience any soiling/streaking without awareness? ☐ Yes ☐ No

Pain

Do you have pelvic or abdominal pain? ☐ Yes ☐ No
Are you currently having sex? ☐ Yes ☐ No If no, why not? ☐ No partner ☐ Pain ☐ Other: _____
Is your partner(s): ☐ Male ☐ Female ☐ Both Any pain with sex? ☐ Never ☐ Occasionally ☐ Most times ☐ Every time
What is the intensity of the pain? ☐ N/A ☐ Mild ☐ Moderate ☐ Severe

Please list all medications that you are currently taking, including over-the-counter and supplements.

Medication Name:	Dosage:	Frequency:

Please list any allergies you may have to medications or food:

_____
_____

Medical History

☐ Headaches
☐ Facial/Jaw Pain
☐ Seasonal Allergies
☐ Asthma
☐ Heartburn/Reflux
☐ Constipation and/or Diarrhea
☐ Poor Sleep
☐ High Blood Pressure
☐ Diabetes
☐ High Cholesterol
☐ Thyroid Problems

Any other medical problems? _____
_____
_____

Surgical History

Hysterectomy? ☐ Yes ☐ No If yes, when? _____
Bladder surgery? ☐ Yes ☐ No If yes, when? _____

Please list any other surgeries you have had and the year performed: _____
_____

OB/GYN History

# of Pregnancies: _____ Deliveries: _____; Vaginally: _____ Cesarean Section: _____
What do you use to prevent pregnancy? _____
Age at first period? _____ Are your periods: ☐ Normal ☐ Heavy ☐ Painful ☐ Irregular
Any history of infections/STDs? _____
When was your last pap smear (year)? _____ Have any ever been abnormal? ☐ Yes ☐ No
When was your last mammogram (year)? _____ When was your last colonoscopy (year)? _____

Family History (Please indicate relationship and age at diagnosis, and don't include yourself.)

☐ Breast Cancer _____ ☐ Ovarian Cancer _____
☐ Colon Cancer _____ ☐ Other: _____

Social History

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner
Do you smoke cigarettes? ☐ Yes ☐ No Do you drink more than one alcoholic beverage a day? ☐ Yes ☐ No
What is your current occupation? _____