



**Ginger N. Cathey, MD
Urogynecology
7900 Fannin, Suite 4000
Houston, TX 77054**

Name: _____

Date of Appointment: _____

Date of Birth: _____

Date Completed: _____

Age: _____

Reason for visit: _____

Please provide name, address and phone number for the following physicians or healthcare providers:

Who referred you to us? _____

Who is your primary care physician? _____

Who is your regular gynecologist? _____

Do you see any specialists?

Name, address, phone number

Gastroenterologist _____

Neurologist _____

Urologist _____

Colorectal Surgeon _____

Other _____

History

URINARY INCONTINENCE

Yes **No**

Do you have accidental loss of urine?

How many months or years have you had leakage of urine?

Do you wear pads to absorb lost urine?

If yes, what size pad do you wear?

How many pads do you wear in a day?

How many trips to the bathroom do you make during the day from the time you wake up in the morning until the time you go to sleep at night?

Does an uncomfortably strong need to pass urine wake you up?

How many times are you awakened during the night after going to sleep by an urge to urinate?

Does the sound, sight or feel of running water cause you to lose urine?

Do you lose urine during the act of intercourse at penetration?

Do you lose urine during orgasm?

I lose urine during coughing, sneezing, running, or heavy lifting

I lose urine with changes in posture, standing or walking

I lose urine continuously such that I am constantly wet

Have you seen a physician for complaints of urine loss?

Have you taken medicine to prevent urine loss?

If yes, name the medication _____

Have you had surgery to prevent urine loss?

If yes, was it done through the vagina?

Was it done through the abdomen?

Do you notice any dribbling or urine when you stand after passing your urine?

Do you usually have difficulty starting your urine stream?

Have you ever required catheterization for the inability to pass your urine?

Do you always feel that your bladder is empty after passing urine?

- Y N Have you seen any blood in your urine?
- Y N Do you have any burning with urination?
- Y N Have you had 3 or more urinary tract infections in the last year?

GENITOURINARY PROLAPSE

- Y N Do you have a bulge or mass in your vagina:
 _____ How many months or years have you had this bulge or mass?
- Y N Have you seen a doctor for this bulge or mass in your vagina?
- Y N Have you worn a pessary for this problem?
 _____ If yes, how many months or years have you worn this pessary?
- Y N Have you had surgery in the past for a bulge or mass in the vagina?

FECAL INCONTINENCE

- Y N Do you have accidental loss of solid stool?
- Y N Do you have accidental loss of liquid stool?
- Y N Do you have accidental loss of gas?
 ___yr___mo How many months or years have you had accidental loss of stool or gas?
- Y N Have you seen a doctor for this problem?
- Y N Did the problem with accidental loss of stool begin after childbirth?
- Y N Do you wear protective pads for this problem?
 _____ If yes, what size pad do you wear?
 _____ How many pads do you wear each day?
- Y N Are you able to sense the need to have a bowel movement?
- Y N Are you able to tell the difference between solid stool/liquid stool/gas?
- Y N Do you have a frequent desire to have a bowel movement?
- Y N Do you feel that your bowels are never completely empty?
- Y N Have you had surgery for this problem?

- Has there been a change in your bowel habits recently?
- Have you noticed any bright red bleeding with your bowel movements?
- Have you noticed black or "tarry" stools?
- Are your bowel movements painful?

CONSTIPATION

- Do you have constipation?
- Do you excessively strain to pass stool more than 25% of the time?
- Do you have at least three bowel movements each week?
- _____ How many bowel movements do you have each week?
- Do you pass hard, small stool?
- __yr__mo How many months or years have you had constipation?
- Have you seen a doctor for this problem?
- Do you use any medication or over the counter products for this?
If yes, what have you used? _____
- Have you had surgery for this problem?
- Have you ever placed your hand or fingers in your vagina or between your vagina and rectum to help bring about a bowel movement?
- Do you have a feeling of incomplete emptying after bowel movements?

PAST GYN HISTORY

Last pap test (month & year): _____

Have you ever had an abnormal pap smear? Yes No If yes, what year? _____

Last mammogram (month & year): _____

Have you ever had an abnormal mammogram? Yes No If yes, what year? _____

- Have you gone through menopause?
If yes, at what age did you go through menopause? _____
If no, are your periods regular? _____
- Have you had any vaginal bleeding or spotting since menopause?
- Have you had a hysterectomy?

INJURIES / ILLNESSES

Date(s) and description(s) of injuries and/or illnesses:

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

<input type="checkbox"/> Y	<input type="checkbox"/> N	Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Skin problems
<input type="checkbox"/> Y	<input type="checkbox"/> N	Pneumonia	<input type="checkbox"/> Y	<input type="checkbox"/> N	Liver problems
<input type="checkbox"/> Y	<input type="checkbox"/> N	Lung disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Thyroid problems
<input type="checkbox"/> Y	<input type="checkbox"/> N	Kidney problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Emotional problems
<input type="checkbox"/> Y	<input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Psychiatric illness
<input type="checkbox"/> Y	<input type="checkbox"/> N	Venereal disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Cancer
<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart trouble/murmur	<input type="checkbox"/> Y	<input type="checkbox"/> N	Ulcers
<input type="checkbox"/> Y	<input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Depression/anxiety
<input type="checkbox"/> Y	<input type="checkbox"/> N	High blood pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Seizures /epilepsy
<input type="checkbox"/> Y	<input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N	Bowel trouble
<input type="checkbox"/> Y	<input type="checkbox"/> N	Rheumatic fever	<input type="checkbox"/> Y	<input type="checkbox"/> N	Glaucoma
<input type="checkbox"/> Y	<input type="checkbox"/> N	Blood disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Arthritis/joint pain
<input type="checkbox"/> Y	<input type="checkbox"/> N	Transfusions	<input type="checkbox"/> Y	<input type="checkbox"/> N	Fracture
<input type="checkbox"/> Y	<input type="checkbox"/> N	Drug or alcohol abuse	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hepatitis / AIDS
<input type="checkbox"/> Y	<input type="checkbox"/> N	Muscle or bone problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Thyroid Disease
<input type="checkbox"/> Y	<input type="checkbox"/> N	Chronic pain	Other _____		

FAMILY HISTORY

Has a **blood-related** family member had any of these illnesses:

Yes	No	Don't Know		Relationship
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prolapse	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary incontinence	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fecal incontinence	_____

PERSONAL AND SOCIAL HISTORY

Who lives in your home with you? _____
Current marital status: Married _____ Divorced _____ Single _____ Widowed _____

Ethnic Background: Caucasian _____ African-American _____
Hispanic _____ Asian _____ Other _____

Are you employed? If so, occupation: _____

Does your job or a hobby require heavy physical work?

Education

Level of Education: _____ Up to 12th Grade _____ Beyond 12th Grade

Personal Habits

Smoking Packs per day: _____ Years of use: _____

Alcohol Drinks per day: _____ Drinks per week: _____

Recreational Drug Use? What type? _____ How often? _____

MEDICATIONS / PRODUCTS / HERBALS

(Please bring medications in the original bottles for us to review)

Name	Dosage	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

_____	Symptoms: _____
_____	Symptoms: _____
_____	Symptoms: _____
_____	Symptoms: _____
_____	Symptoms: _____
_____	Symptoms: _____

REVIEW OF SYSTEMS

Please check appropriate box if any of the following apply to you and these are problems that have not been evaluated prior. If checked, please explain.

Notes

1. Constitutional

- | | | |
|---------------|--------------------------|-------|
| Weight loss | <input type="checkbox"/> | _____ |
| Weight gain | <input type="checkbox"/> | _____ |
| Fever/ Chills | <input type="checkbox"/> | _____ |
| Fatigue | <input type="checkbox"/> | _____ |

2. Eyes

- | | | |
|-------------------|--------------------------|-------|
| Double vision | <input type="checkbox"/> | _____ |
| Spots before eyes | <input type="checkbox"/> | _____ |
| Vision changes | <input type="checkbox"/> | _____ |

3. ENT/Mouth

- | | | |
|-----------------|--------------------------|-------|
| Earaches | <input type="checkbox"/> | _____ |
| Sinus problems | <input type="checkbox"/> | _____ |
| Sore throat | <input type="checkbox"/> | _____ |
| Mouth sores | <input type="checkbox"/> | _____ |
| Dental problems | <input type="checkbox"/> | _____ |

4. Cardiovascular

- | | | |
|---------------------------------|--------------------------|-------|
| Chest pain | <input type="checkbox"/> | _____ |
| Difficult breathing on exertion | <input type="checkbox"/> | _____ |
| Swelling of legs | <input type="checkbox"/> | _____ |
| Palpitations of heart | <input type="checkbox"/> | _____ |

5. Respiratory

- | | | |
|---------------------|--------------------------|-------|
| Wheezing | <input type="checkbox"/> | _____ |
| Spitting up blood | <input type="checkbox"/> | _____ |
| Shortness of breath | <input type="checkbox"/> | _____ |
| Chronic cough | <input type="checkbox"/> | _____ |

6. Gastrointestinal

- | | | |
|-----------------|--------------------------|-------|
| Abdominal Pain | <input type="checkbox"/> | _____ |
| Blood in stool | <input type="checkbox"/> | _____ |
| Nausea/vomiting | <input type="checkbox"/> | _____ |

7. Musculoskeletal

- | | | |
|-----------------|--------------------------|-------|
| Muscle weakness | <input type="checkbox"/> | _____ |
| Joint pain | <input type="checkbox"/> | _____ |
| Back pain | <input type="checkbox"/> | _____ |

REVIEW OF SYSTEMS (Continued)

Notes

- | | | |
|------------------------------------|--------------------------|-------|
| 8. Skin / Breast | | |
| Pain in breast | <input type="checkbox"/> | _____ |
| Discharge | <input type="checkbox"/> | _____ |
| Masses | <input type="checkbox"/> | _____ |
| Rash | <input type="checkbox"/> | _____ |
| Ulcers | <input type="checkbox"/> | _____ |
| 9. Neurological | | |
| Dizzy spells | <input type="checkbox"/> | _____ |
| Seizures | <input type="checkbox"/> | _____ |
| Numbness / tingling | <input type="checkbox"/> | _____ |
| Trouble walking | <input type="checkbox"/> | _____ |
| 10. Psychiatric | | |
| Depression | <input type="checkbox"/> | _____ |
| Frequent Crying | <input type="checkbox"/> | _____ |
| Thoughts of Suicide | <input type="checkbox"/> | _____ |
| 11. Endocrine | | |
| Dry skin | <input type="checkbox"/> | _____ |
| Abnormal thirst | <input type="checkbox"/> | _____ |
| Hot flashes | <input type="checkbox"/> | _____ |
| 12. Hematologic / lymphatic | | |
| Frequent bruises | <input type="checkbox"/> | _____ |
| Cuts that don't stop bleeding | <input type="checkbox"/> | _____ |
| Enlarged lymph nodes | <input type="checkbox"/> | _____ |
| 13. Allergic / immunologic | | |
| Allergies | <input type="checkbox"/> | _____ |
| Drug / Latex allergies | <input type="checkbox"/> | _____ |

Please list any other concerns you may have regarding your medical history and care.

Completed by: Patient Family Member Office Nurse Physician

Signature of patient: _____

Date reviewed by physician with patient: _____

Physician signature: _____