Newton-Wellesley
OBSTETRICS & GYNECOLOGY, P.C.

Follow-up Visit Questionnaire

Urogynecology · Dr. Janet Li

Patient name _____ **Date of birth** _____ **Today's date** _____

Please complete this form before your visit. Click a circle to choose an answer and type in the shaded boxes. When you're done, save the file and return it to our office.

Your symptoms

1 Since your last visit, do you feel that your symptoms are:

◯ Much improved ◯ Slightly improved ◯ Unchanged ◯ Worsened

2 What concerns or questions do you have for me today?

Bladder

3 Do you have trouble voiding (urinating)? ◯ Yes ◯ No

4 Are you having urinary leakage / incontinence? ◯ Yes ◯ No

If you answered "Yes" to question 4:

a. Do you leak with coughing, sneezing, lifting, or laughing? ◯ Yes ◯ No

b. Do you leak with urgency as you are trying to make it to the bathroom? ◯ Yes ◯ No

5 How many times do you urinate during the daytime?

◯ Fewer than 5 times ◯ 5–7 times ◯ 8–10 times ◯ More than 10 times

6 How many times does the urge to urinate wake you from sleep at night?

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 or more

7 Have you been diagnosed with a urinary tract infection recently? ◯ Yes ◯ No

Vaginal bulge

8 Do you feel a bulge in the vagina? ◯ Yes ◯ No

If you answered "Yes" to question 8:

a. Is it worse when you are physically active? ◯ Yes ◯ No

b. Is it worse when you are having a bowel movement? ◯ Yes ◯ No

Bowel

9 Are you having constipation? ◯ Yes ◯ No

10 Are you having incontinence / loss of stool? ◯ Yes ◯ No

If you answered "Yes" to question 10:

a. Are you unaware of it and simply notice stool on your underwear? ◯ Yes ◯ No

b. Do you have bowel urgency and can't quite make it to the bathroom? ◯ Yes ◯ No

Medications

11 What medications do you need refilled?