Newton-Wellesley
OBSTETRICS & GYNECOLOGY, P.C.

Urogynecology
New Patient Intake Form

Name: _____ Preferred name: _____ Age: _____

Pronouns: _____ (e.g. she/her; they/them)

Reason for visit/referral: _____

Referring physician: _____ Specialty: _____

Referring physician address: _____

Primary Care Physician: _____

PCP physician address: _____

Please fill out the Urogynecology Questionnaire on pages 3 and 4.
Feel free to omit the first 2 pages of this form if your information is up to date in the MGB EPIC medical records system. This should be the case if your PCP is a MGB provider.

Past Medical History

Do you currently have, or have you had in the past, any of the following conditions?

- ☐ Glaucoma
- ☐ Lung disease
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Congestive heart failure
- ☐ Blood clots
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Kidney stones
- ☐ Hepatitis/Liver Disease
- ☐ Seizures/Epilepsy
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Parkinson's disease
- ☐ Spinal Bifida
- ☐ Trauma to spinal cord
- ☐ Brain injury
- ☐ Disc herniation
- ☐ Low back pain
- ☐ Diabetes
- ☐ Autoimmune disease
- ☐ Lupus
- ☐ Thyroid disease
- ☐ Depression
- ☐ Anxiety
- ☐ Fibromyalgia

What other medical problems (which are not listed above) do you suffer from?

Past Surgical History

Please list the surgeries you have had:	Year

Past GYN History

Date of last period: _____ Your periods are: ◯ Regular ◯ Irregular

Date of last pap smear test: _____ mm / dd / yyyy

Have you ever had: ☐ Abnormal Pap test ☐ Ovarian cysts ☐ Fibroids

Have you ever used hormone replacement therapy? ◯ Yes ◯ No

Past Obstetrical History

Total number of pregnancies: _____ No. of ectopic pregnancies: _____

No. of vaginal deliveries: _____ No. of Cesarean sections: _____

Birth weight of largest baby delivered vaginally: _____ Forceps/vacuum? ◯ Yes ◯ No

Sexual History (only answer if you are comfortable doing so)

Sexual orientation:
- ◯ Straight/Heterosexual
- ◯ Lesbian/Gay
- ◯ Bisexual
- ◯ Other
- ◯ Decline to state

Assigned sex at birth:
- ◯ Female
- ◯ Male
- ◯ Decline to state

Gender identity:
- ◯ Female
- ◯ Transgender woman
- ◯ Male
- ◯ Transgender man
- ◯ Gender non-conforming
- ◯ Decline to state

Family History

Does any close family member have any of the following?

Condition	Relationship (e.g. Mother)	Condition	Relationship (e.g. Mother)
☐ Heart attack		☐ Bladder/prolapse surgery	
☐ High blood pressure		☐ Colon cancer	
☐ Stroke		☐ Uterine cancer	
☐ Blood clots		☐ Ovarian cancer	
☐ Bleeding disorders		☐ Breast cancer	

What other medical problems run in the family? _____

Social History

Marital status: ◯ Single ◯ Married ◯ Living with partner ◯ Divorced ◯ Other: _____

Current or most recent job: _____

Do you smoke? ◯ Yes ◯ No Have you ever smoked? ◯ Yes ◯ No

How many cigarettes per day? _____ For how many years? _____

Alcoholic beverages per week? _____ Do you take recreational drugs? ◯ Yes ◯ No

Which recreational drugs? _____

Allergies

Medication allergies: _____

Latex allergic? ◯ Yes ◯ No Other allergies: _____

Medications

If your medications are not part of our electronic medical records system, please list all your current medications (include herbal and non-prescription medications):

Medication	Dose	Medication	Dose

Urogynecology Intake Questionnaire

Urinary

Do you experience urinary leakage? ◯ Yes ◯ No

How often? ◯ Less than once a month ◯ A few times a month ◯ A few times a week ◯ Every day/night

How much? ◯ Drops ◯ Small splashes ◯ Pad stays wet ◯ Soaks through to clothes

Do you leak urine with cough, sneezing, running, lifting or other physical activity? ◯ Yes ◯ No

When you have the urge to void, do you ever leak urine before you can sit down or get to the toilet? ◯ Yes ◯ No

Do you urinate frequently during the day? ◯ Yes ◯ No

If yes, how many times do you urinate on an average day? _____

How many times do you get up at night to urinate? _____

Do you leak urine or wet the bed in your sleep? ◯ Yes ◯ No

When you have to urinate, is the urge very strong such that it is hard to delay voiding? ◯ Yes ◯ No

Do you use pads or briefs because of urinary incontinence? ◯ Yes ◯ No

If yes, how many per day? _____

Do you ever have difficulty starting to urinate? ◯ Yes ◯ No

Do you ever have to push up your bladder with your fingers to make it easier to urinate? ◯ Yes ◯ No

Do you feel like you do not empty your bladder completely? ◯ Yes ◯ No

Is your urine flow slow or intermittent? ◯ Yes ◯ No

How many urinary tract infections (bladder infections) have you had in the past 12 months? _____

Do you have pain or burning in the urethra? ◯ Yes ◯ No

Do you have bladder pain or pressure? ◯ Yes ◯ No

Have you ever noticed blood in your urine? ◯ Yes ◯ No

Have you ever had kidney stones? ◯ Yes ◯ No

Have you had prior tests for urinary incontinence or other bladder issues? ◯ Yes ◯ No

Which ones: ☐ Cystoscopy ☐ Urodynamics ☐ Other

Have you had prior treatment(s) for urinary incontinence or other bladder issues? ◯ Yes ◯ No

Which ones:
- ☐ Medications
- ☐ Pelvic floor exercises (Kegels)
- ☐ Pelvic floor physical therapy
- ☐ Urethral injections
- ☐ Surgery
- ☐ Sacral stimulator
- ☐ Tibial nerve/ankle stimulator
- ☐ Other

Which medications have you tried? _____

Do you regularly drink caffeinated beverages (coffee, tea, sodas, energy drinks, etc.)? ◯ Yes ◯ No

If yes, how many cups of caffeinated drinks do you drink each day? _____

Prolapse

Do you usually experience pressure, heaviness or dullness in the pelvic area? ◯ Yes ◯ No

Do you feel tissue bulging out of the vaginal opening? ◯ Yes ◯ No

Does the bulge interfere with your activities such as walking or exercise? ◯ Yes ◯ No

Do you ever feel any tissue bulging from the rectum/anus? ◯ Yes ◯ No

Have you had prior treatment for pelvic organ prolapse? ◯ Yes ◯ No

If yes, what kind? ☐ Pelvic floor exercises ☐ Pessary ☐ Surgery

Gastrointestinal

Do you suffer from constipation? ◯ Yes ◯ No

Do you have to strain for bowel movements on a regular basis? ◯ Yes ◯ No

Do you usually feel like you have not completely emptied your bowels at the end of a bowel movement? ◯ Yes ◯ No

Do you ever have to push up on the vagina, perineum or around the anus to have a bowel movement? ◯ Yes ◯ No

Do you lose stool involuntarily? ◯ Yes ◯ No

Do you usually experience a strong sense of urgency to defecate and have to rush to the bathroom for bowel movements? ◯ Yes ◯ No

Sexual Health

Are you currently sexually active? ◯ Yes ◯ No

Do you feel pain during sexual intercourse? ◯ Yes ◯ No

Do you experience vaginal dryness or irritation? ◯ Yes ◯ No

Do you leak urine with sexual activity? ◯ Yes ◯ No