SHENANDOAH MEDICAL CENTER Michael Woods, MD

Medical History Questionnaire

Reason for today's visit? _____

How long have you had this issue? _____

Are you in pain? ☐ **Yes** ☐ **No** **If yes, how strong (none) 1 2 3 4 5 6 7 8 9 10 (worst) Where?** _____

Are you allergic to any medications? (Please list) _____

Current Medications:

Medication _____ **Dose (i.e. 5mg, 10mg, etc.)** _____

Medication _____ **Dose (i.e. 5mg, 10mg, etc.)** _____

Medication _____ **Dose (i.e. 5mg, 10mg, etc.)** _____

Medical Conditions: (Check all that apply)

☐ Abnormal PAP	☐ Diverticulitis	☐ High Blood Pressure
☐ Anemia	☐ Eating Disorder	(Hypertension)
☐ Anxiety	☐ Endometriosis	☐ Hyperthyroidism
☐ Arrhythmias	☐ Osteoporosis	☐ Hypothyroidism
☐ Asthma	☐ Seizures	☐ Irritable Bowel Syndrome
☐ Bipolar	☐ Ulcerative Colitis	☐ Jaundice
☐ Coronary Artery Disease	☐ Epilepsy	☐ Kidney Disease
☐ Cancer	☐ Gall Bladder Issues	☐ Liver Disease
☐ Congestive Heart Failure	☐ Glaucoma	☐ Migraines
☐ Obesity	☐ Gout	☐Pneumonia
☐ Rheumatoid Arthritis	☐ Hay Fever	☐ Sleep Apnea
☐ Tuberculosis	☐ Hearing Loss	☐ Diabetes
☐ COPD / Lung Disease	☐ Heart Attack	
☐ Crohn's Disease	☐ Hepatitis	Other: _____
☐ Carotid Stenosis	☐ High Cholesterol	
☐ Degenerative Disc Disease	☐ Pancreatitis	
☐ Depression	☐ Sickle Cell Anemia	

Number of Pregnancies: ____ **Number of Births:** ____ **Height:** _____ **Weight:** _____

Pharmacy: _____ **Phone:** _____

PELVIC FLOOR DISTRESS QUESTIONNAIRE

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

☐ Yes ☐ No Do you leak urine when you cough, sneeze, or laugh?

☐ Yes ☐ No Do you regularly have a strong urge to urinate, such that if you do not reach the bathroom quickly enough you feel you will leak?

☐ Yes ☐ No If yes, do you leak before you reach the restroom?

☐ Yes ☐ No Have you wet your bed as an adult? If yes, how often? _____

☐ Yes ☐ No Do you leak during or after sexual intercourse?

How often do you leak? _____ times per ☐ day ☐ week ☐ month ☐ not sure

☐ Yes ☐ No Do you wear a pad because you are leaking?

If yes, how many do you wear per day? _____ What type? _____

☐ Yes ☐ No Have you had any urinary infections in the last year?

☐ Yes ☐ No Do you have pain when you urinate?

☐ Yes ☐ No Do you have blood in your urine?

☐ Yes ☐ No Do you find it hard to start urinating?

☐ Yes ☐ No Do you have a slow urinary stream or have to strain to start urinating?

☐ Yes ☐ No After you urinate, do you feel your bladder is still full?

☐ Yes ☐ No Do you have Glaucoma?

☐ Yes ☐ No Do you have a pacemaker or any metal in your body?

☐ Yes ☐ No Do you lose stool involuntarily?

☐ Yes ☐ No Do you have problems evacuating a bowel movement?

☐ Yes ☐ No Have you ever tried any medication for your bladder problem?

☐ Yes ☐ No Have you ever tried any medication for your bladder problem?

If yes, please list what medications you have tried and if it offered any relief:

_____

☐ Yes ☐ No Has your incontinence greatly impacted your life?

If yes, how does it affect you?

_____

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PELVIC FLOOR DISTRESS INVENTORY

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder or pelvic symptoms and if you do how much they bother you. Answer each question by putting an **X** in the appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the **last 3 months**. (If you answer yes below, please mark how much this bothers you.)

		NO	YES	Not at all	Somewhat	Moderately	Quite a bit
1	Do you usually experience pressure in your lower abdomen?			☐	☐	☐	☐
2	Do you usually experience heaviness or dullness in the lower abdomen?			☐	☐	☐	☐
3	Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?			☐	☐	☐	☐
4	Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?			☐	☐	☐	☐
5	Do you usually experience a feeling of incomplete bladder emptying?			☐	☐	☐	☐
6	Do you ever have to push up in the vaginal area with your fingers to start or complete urination?			☐	☐	☐	☐
7	Do you feel you need to strain too hard to have a bowel movement?			☐	☐	☐	☐
8	Do you feel you have not completely emptied your bowels at the end of a bowel movement?			☐	☐	☐	☐
9	Do you usually lose stool beyond your control if your stool is well formed?			☐	☐	☐	☐
10	Do you usually lose stool beyond your control if your stool is loose or liquid?			☐	☐	☐	☐
11	Do you usually lose gas from the rectum beyond your control?			☐	☐	☐	☐
12	Do you usually have a pain when you pass your stool?			☐	☐	☐	☐
13	Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?			☐	☐	☐	☐
14	Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?			☐	☐	☐	☐
15	Do you usually experience frequent urination?			☐	☐	☐	☐
16	Do you usually experience urine leakage associated with a feeling of urgency; a strong sensation of needing to go to the bathroom?			☐	☐	☐	☐
17	Do you usually experience urine leakage related to laughing, coughing, or sneezing?			☐	☐	☐	☐
18	Do you usually experience small amounts of urine leakage (that is, drops)?			☐	☐	☐	☐
19	Do you usually experience difficulty emptying your bladder?			☐	☐	☐	☐
20	Do you usually experience pain or discomfort in the lower abdomen or genital region?			☐	☐	☐	☐

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SOMATIZATION QUESTIONNAIRE

During the past week, did you suffer from:	YES	NO
Dizziness or feeling light-headed?		
Painful muscles?		
Fainting?		
Neck pain?		
Back pain?		
Excessive perspiration?		
Palpitations?		
Headache?		
A bloated feeling in the abdomen?		
Blurred vision or spots in front of your eyes?		
Shortness of breath?		
Nausea or an upset stomach?		
Pain in the abdomen or stomach area?		
Pressure or tight feeling in the chest?		
Pain in the chest?		
Feeling down or depressed?		
Sudden shock for no reason?		
Worry?		
Disturbed sleep?		
Indefinable feeling of fear?		
Listlessness?		
Trembling when with other people?		
Anxiety or panic attacks?		
During the past week, did you feel:	**YES**	**NO**
Tense?		
Easily irritated?		
Frightened?		
That everything is meaningless?		
That you just can't do anything anymore?		
That life is not worthwhile?		
That you can no longer take interest in people or things around you?		
That you can't cope anymore?		
That you would be better off if you were dead?		
That you can't enjoy anything anymore?		
That you can't face it anymore?		
During the past week:	**YES**	**NO**
Did you easily become emotional?		
Were you afraid of anything when there was no need to be afraid?		
Were you afraid to travel on buses, trains, or trams?		
Did you ever feel as if you were being threatened by unknown danger?		
Did you ever think "if only I was dead"?		
Did you ever have fleeting images of any upsetting events that you experienced?		
Did you ever have to do your best to put aside thoughts about upsetting events?		
Did you have to avoid certain places because they frightened you?		
Did you have to repeat some actions a number of times before you could do something else?		

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SEXUAL FUNCTION SURVEY

Q1. Which of the following best describes you:

Not sexually active at all	☐ --->	**Continue to Section 1**
Sexually active with or without a partner	☐ --->	**Continue to Section 2**

Section 1: For those who are NOT sexually active

Q2. For each reason below, please indicate how strongly you agree or disagree as a reason that you are not sexually active.	**Strongly Agree**	**Somewhat Agree**	**Somewhat Disagree**	**Strongly Disagree**	
No partner	☐ 1	☐ 2	☐ 3	☐ 4	
No interest	☐ 1	☐ 2	☐ 3	☐ 4	
Bladder or bowel problems or due to prolapse	☐ 1	☐ 2	☐ 3	☐ 4	
Other health problems	☐ 1	☐ 2	☐ 3	☐ 4	
Pain	☐ 1	☐ 2	☐ 3	☐ 4	

Q3. How much does the fear of leaking urine, stool, and/or a bulging in the vagina cause you to avoid or restrict your sexual activity?

1 ☐ Not at all

2 ☐ A little bit

3 ☐ Sometimes

4 ☐ A lot

Q4. For each of the following, please circle the number between 1 and 4 that best represents how you feel about your sex life.					
a. Satisfied	**1**	**2**	**3**	**4**	**Dissatisfied**
b. Adequate	**1**	**2**	**3**	**4**	**Inadequate**

Q5. How strongly do you agree or disagree with each of the following statements?	**Strongly Agree**	**Somewhat Agree**	**Somewhat Disagree**	**Strongly Disagree**
I feel frustrated by my sex life	☐ 1	☐ 2	☐ 3	☐ 4
I feel sexually inferior because of my incontinence and/or prolapse	☐ 1	☐ 2	☐ 3	☐ 4
I feel angry because of the impact that incontinence and/or prolapse has on my sex life.	☐ 1	☐ 2	☐ 3	☐ 4

Q6. Overall, how bothersome is it to you that you are not sexually active?

1 ☐ Not at all

2 ☐ A little bit

3 ☐ Sometimes

4 ☐ A lot

End of Items for Not Sexually Active

Section 2: For those who are sexually active

Q7. How often do you feel sexually aroused (physically excited or turned on) during sexual activity?

1 ☐ Never

2 ☐ Rarely

3 ☐ Sometimes

4 ☐ Usually

5 ☐ Always

Q8. When you are involved in sexual activity, how often do you feel each of the following:	Never	Rarely	Sometimes	Usually	Almost Always
a. Fulfilled	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. Shame	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. Fear	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Q9. How often do you leak urine and/or stool with <u>any type</u> of sexual activity?

1 ☐ Never

2 ☐ Rarely

3 ☐ Sometimes

4 ☐ Usually

5 ☐ Always

Q10. Compared to orgasms you have had in the past, how intense are your orgasms now?

1 ☐ Much less intense

2 ☐ Less intense

3 ☐ Same intensity

4 ☐ More intense

5 ☐ Much more intense

Q11. How often do you feel pain during sexual intercourse?
(If you don't have intercourse check this box ☐ and skip to the next question.)

1 ☐ Never

2 ☐ Rarely

3 ☐ Sometimes

4 ☐ Usually

5 ☐ Always

Q12. Do you have a sexual partner?

Yes ☐ ---> Go to next question

No ☐ ---> Go to Q15

Q13. How often does your partner have a problem (lack of arousal, desire, erection, etc.) that limits your sexual activity?

1 ☐ All of the time

2 ☐ Most of the time

3 ☐ Some of the time

4 ☐ Hardly ever/Rarely

Q14. In general, would you say that your partner has a positive or negative impact on each of the following:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative	
a. Your sexual desire	☐ 1	☐ 2	☐ 3	☐ 4	
b. The frequency of your sexual activity	☐ 1	☐ 2	☐ 3	☐ 4	

Q15. When you are involved in sexual activity, how often do you feel that you want more?

1 ☐ Never

2 ☐ Rarely

3 ☐ Sometimes

4 ☐ Usually

5 ☐ Always

Q16. How frequently do you have sexual desire, this may include wanting to have sex, having sexual thoughts or fantasies, etc.?

1 ☐ Daily

2 ☐ Weekly

3 ☐ Monthly

4 ☐ Less often than once a month

5 ☐ Never

Q17. How would you rate your level (degree) of sexual desire or interest?

1 ☐ Very high

2 ☐ High

3 ☐ Moderate

4 ☐ Low

5 ☐ Very low or none at all

Q18. How much does the fear of leaking urine, stool and/or a bulging in the vagina (prolapse) cause you to avoid sexual activity?

1 ☐ Not at all

2 ☐ A little

3 ☐ Some

4 ☐ A lot

Q19. For each of the following, please check the number between 1 and 4 that best represents how you feel about your sex life.					
a. Satisfied	☐ 1	☐ 2	☐ 3	☐ 4	Dissatisfied
b. Adequate	☐ 1	☐ 2	☐ 3	☐ 4	Inadequate
c. Confident	☐ 1	☐ 2	☐ 3	☐ 4	Not Confident

Q20. How strongly do you agree or disagree with each of the following statements:	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
a. I feel frustrated by my sex life	☐ 1	☐ 2	☐ 3	☐ 4
b. I feel sexually inferior because of my incontinence and/or prolapse	☐ 1	☐ 2	☐ 3	☐ 4
c. I feel embarrassed about my sex life.	☐ 1	☐ 2	☐ 3	☐ 4
d. I feel angry because of the impact that incontinence and/or prolapse has on my sex life.	☐ 1	☐ 2	☐ 3	☐ 4

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MENSTRUATION HISTORY

Age started: _____

First day of last menstrual period: _____

Number of days your period lasts: _____

Number of days from start of period next: _____

Present menstrual cycle: ☐ Regular ☐ Irregular

Date of last PAP Smear: _____

Date of last Mammogram: _____

Are you currently worried or afraid of being hit or abused? _____

Do you have a history of being sexually or physically abused? _____

Are you sexually active? ☐ Yes ☐ No If yes, with ☐ Male ☐ Female

If yes, are you: ☐ Monogamous (one partner) for _____ months/years

☐ Not monogamous (multiple partners) for _____ months/years

If yes, is anything used to prevent pregnancy: ☐ Pills ☐ Condoms ☐ Diaphragm

☐ Withdrawal Method ☐ Vasectomy ☐ Tubal Ligation (tubes tied) ☐ Other:_____

Any chance you might be pregnant now? _____

Any history of sexually transmitted disease(s)? ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ HPV

☐ Trichomoniasis ☐ Syphilis ☐ Other:_____

FAMILY HISTORY

Please check any of the following health problems that occur in your family:

☐ Birth Defects ☐ Mental Illness ☐ Thyroid Problems ☐ Breast Cancer ☐ Arthritis ☐ Diabetes

☐ High Blood Pressure ☐ Osteoporosis ☐ TB ☐ Stroke ☐ Heart Disease ☐ Cancer ☐ Colon Cancer

☐ Ovarian Cancer ☐ Uterus Cancer ☐ Blood Clots (legs, lungs, etc.)

Major illnesses or cause of death:

Father:_____

Paternal Grandfather:_____

Paternal Grandmother:_____

Mother:_____

Maternal Grandfather:_____

Maternal Grandmother:_____

Brothers and/or Sisters:_____

SOCIAL HISTORY

Occupation:_____ ☐ Full-time ☐ Part-time

Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____ How many years? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day or week? _____

Do you exercise for more than 30 minutes, 3-5 times weekly? ☐ Yes ☐ No

Do you consistently eat foods that are fried or high in fat? ☐ Yes ☐ No

Date of last cholesterol screening:_____

Do you use illegal/recreational drugs now or have you used any in the past? ☐ Yes ☐ No

If yes, please list:_____

Do you wear your seatbelt regularly? ☐ Yes ☐ No