Providence Urogynecology
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Providence

NAME: ______________________

INTAKE QUESTIONS

What concern brings you in today? ____

____

How long have you been having said concern? ______________________________

UROGYN QUESTIONS

Question	YES	NO
Do you leak urine when you cough/sneeze/laugh/exercise?	☐ YES	☐ NO
Do you experience frequent urination?	☐ YES	☐ NO
How many times do you urinate during the day (while awake)? ______At night (sleeping hours)? ______		
Do you experience urine leakage associated with a strong sense of urgency to urinate (a sudden need to rush to the bathroom)?	☐ YES	☐ NO
Do you wear pads to protect against urine leakage?	☐ YES	☐ NO
Do you feel that it is difficult to empty your bladder?	☐ YES	☐ NO
Do you leak urine during intercourse or orgasm?	☐ YES	☐ NO
Have you ever been on a medication for your bladder problems? If so, what is the name of the medication? ___________________	☐ YES	☐ NO
Do you get bladder infections frequently? Number in the past year:______	☐ YES	☐ NO
Have you ever had bloody urine (not from the vagina or rectum)?	☐ YES	☐ NO

Question	YES	NO
Do you feel like your pelvic organs are falling out? Bulge in your vagina?	☐ YES	☐ NO

COLUMBIA SURGICAL SPECIALISTS

Professional services provided by Columbia Surgical Specialists and Spokane Ear, Nose & Throat

If you have vaginal prolapse or feel a vaginal bulge, do you have to push it inside to urinate or have a bowel movement? ☐ YES ☐ NO

Have you ever used vaginal estrogen cream? ☐ YES ☐ NO

Do you ever leak stool? ☐ YES ☐ NO

How are your bowel movements? ☐ normal ☐ constipated ☐ diarrhea

UROGENITAL HISTORY:

Do you have a history of any of the following?

- ☐ Hysterectomy
- ☐ Removal of ovaries
- ☐ Surgery for prolapse (cystocele or rectocele)
- ☐ Surgery for urinary incontinence
- ☐ Cervical, uterine, or ovarian cancer
- ☐ Kidney or bladder surgery
- ☐ Abnormal kidneys
- ☐ Recurrent urinary or bladder infections
- ☐ Kidney stones
- ☐ Abnormal vaginal or uterine bleeding
- ☐ Hormone therapy (eg estrogen)
- ☐ Genital Herpes

SEXUAL ORIENTATION AND GENDER IDENTITY

Are you sexually active? ☐ YES ☐ NO

My current gender identity is (eg male/female/transgender): ______________________________

My sexual orientation is (eg straight/lesbian/bisexual/queer): ______________________________

My pronouns are (eg She/Her, He/Him, They/Them): ______________________________

OBSTETRIC HISTORY

Total number of times pregnant: __

Number of vaginal deliveries: _ Number of cesarean sections: _Largest baby weight:___

Were forceps used during delivery? ☐ YES ☐ NO

Was a vacuum used during delivery? ☐ YES ☐ NO

Did you have a tear through the rectum (3rd or 4th degree)? ☐ YES ☐ NO

HEALTH SCREENING

Date of last mammogram: __________ ☐ NORMAL ☐ ABNORMAL ☐ NEVER HAD

Date of last colonoscopy: __________ ☐ NORMAL ☐ ABNORMAL ☐ NEVER HAD

Date of last pap smear: __________ ☐ NORMAL ☐ ABNORMAL ☐ NEVER HAD

Would you like to receive emails for educational information about pelvic floor topics? ☐YES ☐NO