UTHealth | McGovern Medical School
The University of Texas Health Science Center at Houston

UT★Physicians
A Part of UTHealth
- Urogynecology Center at Memorial City
- Urogynecology Center at Sugar Land
- Women's Center at TMC - Urogynecology
- Women's Center at Bellaire - Urogynecology

Urogynecology New Patient Form

Today's Date:			
Appointment Date:			
PATIENT INFORMATION			
Patient Name:		Marital status:	
Is this your legal name?	If not, what is your legal name?	Birth date:	Age:
Reason for Visit:			

Please provide Name, Address, Phone Number, and Fax Number for the following Physicians or Healthcare Providers	
Who Referred You to Us? / How Did You Hear of Us?	
Primary Care Physician	
Regular Gynecologist	
Specialist:	
Colorectal Surgeon	
Gastroenterologist	
Cardiologist	
Urologist	
Other	

Urinary Incontinence	**Yes**	**No**
Do you have accidental loss of urine?	☐	☐
How many months or years have you had leakage of urine?	Yrs. Month/s	
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 until 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 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?	☐	☐
Do you lose urine during coughing, sneezing, running, or lifting?	☐	☐
Do you lose urine with changes in posture, standing, or walking?	☐	☐
Do you lose urine continuously such that you are constantly wet?	☐	☐
Have you seen a physician for complaints of urine loss?	☐	☐
Have you taken medicine to prevent urine loss? If yes, name of 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 starting your urine stream?	☐	☐
Have you ever required catheterization for the inability to pass urine?	☐	☐
Do you always feel that your bladder is empty after passing urine?	☐	☐
Have you seen any blood in your urine?	☐	☐
Do you have any burning with urination?	☐	☐
Have you had 3 or more urinary tract infections in the last year?	☐	☐

Genitourinary Prolapse	**Yes**	**No**
Do you have a bulge or mass in your vagina?	☐	☐
How many months or years have you had this bulge or mass?	Yrs. Month/s	
Have you seen a doctor for this bulge or mass in your vagina?	☐	☐
Have you worn a pessary for this problem?	☐	☐
If Yes, How many months or years have you worn this pessary?	Yrs. Month/s	
Have you had surgery in the past for a bulge or mass in the vagina?	☐	☐
Fecal Incontinence	**Yes**	**No**
Do you have accidental loss of solid stool?	☐	☐
Do you have accidental loss of liquid stool?	☐	☐
Do you have accidental loss of gas?	☐	☐
How many months or years have you had accidental loss of stool or gas?	Yrs. Month/s	
Have you seen a doctor for this problem?	☐	☐
Did the problem with accidental loss of stool begin after childbirth?	☐	☐
Do you wear protective pads for this problem?	☐	☐
How many pads do you wear each day?		
Are you able to sense the need to have a bowl movement?	☐	☐
Are you able to tell the difference between solid stool, liquid stool, or gas?	☐	☐
Do you have a frequent desire to have a bowel movement?	☐	☐
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	**Yes**	**No**
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?	☐	☐
How many months or years have you had constipation	Yrs. Month/s	
Have you seen a doctor for this problem?	☐	☐
Have you taken medication or over the counter products for this? If yes, name of medication _____	☐	☐
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 about a bowel movement?	☐	☐
Do you have a feeling of incomplete emptying after bowel movements?	☐	☐
Have you had a colonoscopy? Date: _____ Results _____	☐	☐
Past GYN History	**Yes**	**No**
Last pap test	Yr. Month	
Have you ever had an abnormal pap smear? If Yes, What year? _____	☐	☐
Last Mammogram	Yr. Month	
Have you ever had an abnormal mammogram? If Yes, What year? _____	☐	☐
Have you gone through menopause? If Yes, at what age? _____	☐	☐
Are your periods regular? How many days do you bleed? _____	☐	☐
Have you had any vaginal bleeding or spotting since menopause?	☐	☐
Have you had a hysterectomy? If Yes, was it done through the Vagina? ☐ Abdomen? ☐ Laparoscopically? ☐	☐	☐
Do you have your ovaries? If Yes, Both? ☐ Only One? ☐	☐	☐

Past Obstetrical History		
Number of Pregnancies	#	
Number of Vaginal Births	Vacuum #	Forceps #
Number of C-Sections	#	
Weight of Largest Baby		

Sexual History	**Yes**	**No**
Are you Sexually Active?	☐	☐
If No, Please select from the following:		
No partner?	☐	☐
Partner factor?	☐	☐
Loss of sex drive?	☐	☐
Painful intercourse?	☐	☐
Because of bulge or leak symptoms?	☐	☐
Other:		
Partner: Male ☐ Female ☐ Both ☐		
Do you use contraception?	☐	☐
If Yes, Please select from the following:		
Tubal ligation?	☐	☐
Birth control pills?	☐	☐
Intrauterine device IUD?	☐	☐
Diaphragm?	☐	☐
Depo-Provera?	☐	☐
Barrier?	☐	☐
Postmenopausal?	☐	☐
Other:		
Do you have pain with intercourse?	☐	☐
If Yes, Near Vaginal Opening? ☐ Inside abdomen/pelvic area? ☐ Both? ☐		

Surgeries/Hospitalizations
Date(s) and Reason(s) for surgery/hospitalization:
Any problems with anesthesia during any surgeries?
Explain:
Injuries/Illnesses
Date(s) and description(s) of injuries and/or illnesses:

Do you currently have, have had, or have you been diagnosed for any of the following:

	Yes	No		Yes	No
Asthma	☐	☐	Skin problems	☐	☐
Pneumonia	☐	☐	Liver problems	☐	☐
Lung disease	☐	☐	Thyroid disease	☐	☐
Kidney problems	☐	☐	Gastric Reflux	☐	☐
Tuberculosis	☐	☐	Psychiatric illness	☐	☐
Venereal disease	☐	☐	Cancer	☐	☐
Heart trouble/murmur	☐	☐	Ulcers	☐	☐
Diabetes	☐	☐	Depression/anxiety	☐	☐
High blood pressure	☐	☐	Seizures/epilepsy	☐	☐
Stroke	☐	☐	Bowel trouble	☐	☐
Migraine headaches	☐	☐	Glaucoma	☐	☐
Blood disorders	☐	☐	Arthritis/joint pain	☐	☐
Transfusions	☐	☐	Fracture	☐	☐
Drug or alcohol abuse	☐	☐	Hepatitis/AIDS	☐	☐
Muscle or bone problems	☐	☐	High Cholesterol	☐	☐
Chronic pain	☐	☐	Other:		

Medications/Products/Herbals

(Please bring medication in the original bottles for us to review if not recorded)

Name	Dosage	How Often

Allergies	Symptoms

Family History

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

	Yes	No	Don't Know	Relationship
Diabetes	☐	☐	☐	
Stroke	☐	☐	☐	
Heart disease	☐	☐	☐	
High blood pressure	☐	☐	☐	
Breast cancer	☐	☐	☐	
Colon cancer	☐	☐	☐	
Ovarian cancer	☐	☐	☐	
Prolapse	☐	☐	☐	
Urinary incontinence	☐	☐	☐	
Fecal incontinence	☐	☐	☐	

Personal and Social History

Who lives in your home:

Current marital status: Married? ☐ Divorced? ☐ Single? ☐ Widowed? ☐

Ethnic Background: Caucasian? ☐ African-American? ☐ Hispanic? ☐

Asian? ☐ Other? ☐

	Yes	No
Are you employed?	☐	☐
Does your job or a hobby require physical work?	☐	☐

Education

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

Personal Habits

	Yes	No		
Smoking	☐	☐	Packs per day:	Years of use:
Alcohol	☐	☐	Drinks per day:	Drinks per week:
Recreational Drug Use	☐	☐	What type?	How often?

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

	Yes	No	Notes
Constitutional			
Weight loss	☐	☐	
Weight gain	☐	☐	
Fever/Chills	☐	☐	
Fatigue	☐	☐	
Eyes			
Double vision	☐	☐	
Spots before eyes	☐	☐	
Vision changes	☐	☐	
ENT/Mouth			
Ear aches	☐	☐	
Sinus problems	☐	☐	
Sore throat	☐	☐	
Mouth sores	☐	☐	
Dental problems	☐	☐	
Cardiovascular			
Chest pain	☐	☐	
Difficult breathing on exertion	☐	☐	
Swelling of legs	☐	☐	
Palpitations of heart	☐	☐	
Respiratory			
Wheezing	☐	☐	
Spitting up blood	☐	☐	
Shortness of breath	☐	☐	
Chronic cough	☐	☐	
Gastrointestinal			
Abdominal pain	☐	☐	
Blood in stool	☐	☐	
Nausea/vomiting	☐	☐	
Musculoskeletal			
Muscle weakness	☐	☐	
Joint pain	☐	☐	
Back pain	☐	☐	

Review of Systems - Continued

	Yes	No	Notes
Skin/Breast			
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	
Neurological			
Dizzy spells	☐	☐	
Seizures	☐	☐	
Trouble walking	☐	☐	
Numbness/tingling	☐	☐	
Psychiatric			
Depression	☐	☐	
Frequent Crying	☐	☐	
Thoughts of suicide	☐	☐	
Endocrine			
Dry skin	☐	☐	
Abnormal thirst	☐	☐	
Hot flashes	☐	☐	
Hematologic/lymphatic			
Frequent bruises	☐	☐	
Cuts that do not stop bleeding	☐	☐	
Enlarged lymph nodes	☐	☐	
Allergic/immunologic			
Allergies	☐	☐	
Drug/latex allergies	☐	☐	
Please list any other concerns you may have regarding your medical history and care			

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Completed by: Patient ☐ Family Member ☐ Office Nurse ☐ Physician ☐
Signature of patient:
Date reviewed by physician with patient:
Physician signature: