University of Colorado Urogynecology/Pelvic Reconstructive Surgery Division
New Patient In-Take Form

Name_____ **Date of Birth** _____ **Age** _____
Referring Doctor_____ **Primary Care M.D.**_____
Gynecologist_____**Cardiologist**_____
Gastroenterologist_____

Reason(s) for visit (*check all that apply*):

☐Cystocele (Bladder Prolapse)	☐ Intrinsic sphincter deficiency	☐Urinary frequency
☐Enterocele (Bowl prolapse)	☐ Sling Mesh Erosion	☐Urinary incontinence
☐Enuresis (Bed wetting)	☐ Recurrent UTI	☐Urinary urgency
☐Nocturia (Night time frequency)	☐ Fecal incontinence with fecal urgency	☐Uterine prolapse
☐Pelvic organ prolapse	☐ Mixed incontinence	☐ Prolapse after Hysterectomy
☐Pelvic pain	☐ Continuous leakage of urine	☐ Chronic constipation
☐Rectocele	☐ Levator spasms	☐ Problem from Sling
☐Stress incontinence	☐ Urinary retention	☐ Problem from Mesh
☐Urgency incontinence	☐ Fecal Incontinence	☐ Other: _____
☐ Vagina mesh erosion	☐ Incomplete bladder emptying	

How long have you had these symptoms?
☐Less than 1 month ☐1 – 6 months ☐7 - 12 months ☐2 - 5 years

☐6 -10 years ☐10 – 20 years ☐More than 20 years

Please describe the severity of your symptoms since they began:
☐Improving ☐Stable ☐Worsening

Pelvic Floor Symptoms:
If you urinate, how long can you wait before you feel like you *must* urinate again?

☐Less than 30 minutes ☐ 1 – 2 hours ☐ 4 or more hours
☐ 30 minutes – 1 hour ☐ 2 -3 hours

How many times do you get up at night because you feel like you *must* urinate?
☐1 time ☐ 1 – 2 times ☐ 2 times ☐2 – 3 times ☐ 3 or more times ☐ None

Do you leak urine or does urine seep out when you do not want it to?
☐Yes ☐No

Leakage:
Urgency (how many times do you rush to get to the bathroom?) _____ Times a day

Do you leak without being aware? ☐ Yes ☐ No

How much urine are you leaking?
☐ None ☐ Small splash
☐Drops ☐ More

How often do you have inability to control urination?
☐ Everyday ☐ Few times a week ☐ Less than once a month
☐ Every Night ☐ Few times a month

What forms of protection do use to counter the leaking? (*check all that apply*)

☐ Sanitary pads ☐ Panty liners ☐ Absorbent underwear (Thinx)
☐ Diapers ☐ Tissue paper ☐ Other: _____

How many do you typically use? _____ Per Day OR _____Per Week

Does coughing/sneezing/or laughing cause you to leak? ☐ Yes ☐ No
If so, which ones: ☐ Coughing ☐ Sneezing ☐ Laughing

How often do you have inability to control urination?
☐ Everyday ☐ Few times a week ☐ Less than once a month
☐ Every Night ☐ Few times a month

Surgical History:
Have had any previous surgery for incontinence? (urine loss) ☐ No ☐ Yes Date: _____
If yes, type of surgery: _____

Have you had any previous surgery for pelvic relaxation/prolapse? ☐ No ☐ Yes Date: _____
If yes, type of surgery: _____
Have you had a hysterectomy? ☐ No ☐ Yes Date: _____
Type: ☐ Abdominal ☐ Vaginal ☐ Laparoscopic/Robotic
Ovaries: ☐ Were not removed ☐ One removed ☐ Both removed
If one ovary removed, which one? ☐ Left ☐ Right
Have you had any other procedures on the urinary tract? (*Check all that apply, list month/year*):
☐ Urethral dilation _____ ☐ Cystoscopy _____ ☐ Urodynamics (bladder testing) _____
☐Urethral Bulking _____ ☐ Bladder distention _____ ☐ BOTOX

Other Prior Surgeries: (Heart, gallbladder, appendix, D&C etc.) ☐No other surgeries

Date (month/year)	Surgical Procedure	Surgeon	Hospital

Did you experience problems with anesthesia with any of these surgeries?
☐ No ☐ Yes

If yes, please describe what happened: _____
_____

Medical History:
(Please check all conditions that apply to you)

☐ Arthritis
☐ Asthma/COPD
☐ Blood clots
☐ Cancer (type: _____)
☐ Depression or Anxiety
☐ Diabetes
☐ Spinal Stenosis
☐ Fibromyalgia
☐ GERD/Reflux
☐ Heart Attack
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Inflammatory Bowel Disease
☐ Irritable Bowel Syndrome (IBS)
☐ Neurological Disease
☐ Stroke
☐ Thyroid Disease
☐ Blood Transfusion

Other conditions not listed or details from those checked off:
_____
_____

Allergies: ☐ I have no known allergies to any medications, food, or materials

Allergy	Reaction

Urogenital History:
Do you have a history of the following? *(check all that apply)*
☐ Recurrent urinary tract infections (UTI) ☐ Pyelonephritis (kidney infections) ☐ Hematuria (blood in urine)
☐ Nephrolithiasis (kidney stones) ☐ Abnormal kidneys (one kidney, renal cysts, duplicated ureter)

Family History:
Do you have any family history of Incontinence or Pelvic organ prolapse? ☐ Yes ☐ No ☐ Unknown

Who in your family? (*Check all that apply*)
☐ Mother ☐ Sibling ☐ N/A ☐ Father ☐ Grandparent

Are you currently experiencing any of the following **urinary symptoms**?
1. Burning when you urinate ☐ Yes ☐ No
2. Blood in your urine ☐ Yes ☐ No
3. Difficulty/ emptying your ladder ☐ Yes ☐ No
4. Dribbling urine out after you wipe ☐ Yes ☐ No
5. More than 2 urinary tract infections in the last 6 months ☐ Yes ☐ No
6. Prior kidney infection ☐ Yes ☐ No
7. Kidney stones ☐ Yes ☐ No
8. Kidney disease ☐ Yes ☐ No

Do you **SEE or FEEL** a bulge in your vagina? ☐ Yes ☐ No
Do you have to push on the bulge to help you urinate? ☐ Yes ☐ No
Do you have to push on the bulge to help you have a bowel movement? ☐ Yes ☐ No

Bowel symptoms:

Frequency of bowel movement: _____ Time(s) a day **OR** _____ Times a week

Consistency of stool:
☐ Separate, hard lumps (hard to pass) ☐ Smooth and long ☐ Easily passed soft lumps
☐ Lumpy and sausage like ☐ Fluffy, mushy pieces with ragged edges ☐ Entirely liquid
☐ Other: _____

Constipation medicine:
☐ Dulcolax ☐ Probiotics ☐ Other: _____
☐ Miralax ☐ Fiber supplements ☐ None

Incomplete stool evacuation? ☐ Yes ☐ No
Do you have to use your finger to get stool out completely? ☐ Yes ☐ No
Do you notice loose stool in your underwear/pad unintentionally? ☐ Yes ☐ No

Sexual activity:

Relationship status:
☐ Married ☐ Single ☐ Widowed
☐ Boyfriend/Girlfriend ☐ Divorced ☐ Other: _____

Sexually active: ☐ Yes ☐ No
If Yes, with who? ☐ Male ☐ Female ☐ Both

Sexual problems (*Check all that apply*):
☐ Pain with sex ☐ Incompatibility with partner ☐ Other: _____
☐ Low libido ☐ STD's

Do you leak with vaginal penetration? ☐ Yes ☐ No
Do you leak when having an orgasm? ☐ Yes ☐ No

Regular exercise (per week):

What exercise activity do you do? (*Check all that apply*)
☐ Aerobic (jogging, walking) ☐ Flexibility (yoga, light stretches)
☐ Strength (lifting weights, resistance machines) ☐ Balance (standing on one foot, heel-toe walking)

How much time do you spend on exercising weekly? _____ Hours a week
Do you have leakage when exercising? ☐ Yes ☐ No

Health Habits:

Do you smoke or use tobacco? ☐ Yes ☐ No
Do you smoke or use Marijuana? ☐ Yes ☐ No
Do you use illegal drugs of any kind? ☐ Yes ☐ No Last Used: _____

Dietary/lifestyle habits (Average cups/day):

Water _____cups
Coffee _____cups
Tea _____cups
Soda/carbonated beverages _____cups
Citric beverages _____cups
Alcohol _____drink(s)
Spicy Foods _____ Times a week

Gynecologic History: Are you post- menopausal?

☐ No	☐ Yes
Date of last menstrual period: / /	How old were you when you experienced your last menstrual period? _____ Years old
Describe your current periods (check all that apply): ☐ Regular ☐ Irregular ☐ Painful ☐ Heavy	
How often do you get your period? _____ days How long do your periods last? _____days	Have you experienced any post- menopausal bleeding? ☐ Yes ☐ No
What do you use to prevent pregnancy? ☐ N/A ☐ Pill/Patch/Ring ☐ Depo-Provera ☐ IUD ☐ Barrier method ☐ Tubal Ligation ☐ Vasectomy	Are you taking any hormone therapy (estrogen or progesterone)? ☐ Yes ☐ No Oral/Patch? ☐ Yes ☐ No Vagina/topical? ☐ Yes ☐ No

Obstetric History:

Total number of times you have been pregnant: _____
How many vaginal deliveries have you had? _____
How many c-sections have you had? _____
What was the weight of your largest baby? _____lbs. _____ oz.
Were forceps used during delivery? ☐ Yes ☐ No ☐ I don't remember
Was a vacuum used during delivery? ☐ Yes ☐ No ☐ I don't remember
Did you have an episiotomy or any lacerations? ☐ Yes ☐ No ☐ I don't remember
Desire for future fertility? ☐ Yes ☐ No

Health maintenance:

When was your last pap smear (year/Date)? / /
- Pap smear findings? ☐ Normal ☐ Abnormal

If abnormal, what procedure was done?
☐ Colposcopy ☐ LEEP ☐ Cervical Biopsy ☐ Other: _____

When was your last mammogram (year/Date)? / /
- Mammogram findings? ☐ Normal ☐ Abnormal

When was your last colonoscopy (year/Date)? / /
- Colonoscopy findings? ☐ Normal ☐ Abnormal