Welcome to the CU Urogynecology practice. We are happy that you chose our team to help you better understand and treat your pelvic floor symptoms. Cu Urogynecology provides a multidisciplinary pelvic health program, with urogynecology, colorectal, urology, and physical therapy experts working in partnership to cure interrelated pelvic floor disorders women face. Below you will find a compare symptoms and medical history questionnaire that will help us to make sure all your needs are met.

<table>
<thead>
<tr>
<th>Name ____________________________</th>
<th>Date of Birth ___________________</th>
<th>Age ______</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referring Doctor</strong></td>
<td><strong>Primary Care Provider</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Gynecologist</strong></td>
<td><strong>Cardiologist</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Gastroenterologist</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reason(s) for visit (check all that apply):**
- [ ] Dysuria (Burning with urination)
- [ ] Cystocele (bladder prolapse)
- [ ] Rectocele
- [ ] Hematuria (blood in urine)
- [ ] Enterocoele (bowl prolapse)
- [ ] Intrinsic sphincter deficiency
- [ ] Enuresis (bed wetting)
- [ ] Pelvic Organ Prolapse
- [ ] Chronic constipation
- [ ] Nocturia (nighttime frequency)
- [ ] Uterine Prolapse
- [ ] Sling mesh erosion
- [ ] Continuous leakage of urine
- [ ] Prolapse after Hysterectomy
- [ ] Vagina mesh erosion
- [ ] Urinary retention
- [ ] Urgency Incontinence
- [ ] Problem from mesh
- [ ] Incomplete bladder emptying
- [ ] Urinary Incontinence
- [ ] Problem from sling
- [ ] Recurrent UTI
- [ ] Stress Incontinence
- [ ] Other: ____________________
- [ ] Urinary frequency
- [ ] Mixed Incontinence

How long have you had these symptoms?
- [ ] Less than 1 month
- [ ] 1 – 6 months
- [ ] 7 – 12 months
- [ ] Greater than a year
- [ ] 5 years or more

Please describe the severity of your symptoms since they began:
- [ ] Improving
- [ ] Stable
- [ ] Worsening

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

How many UTIs have you had in the past year?
- [ ] 0
- [ ] 1-2
- [ ] 3 or more

If two or more, was a culture done to prove that an infection was present?
- [ ] Yes
- [ ] No

For the section below please check the box that best fits your symptoms and answer how much does it bother you:

![Image of a woman doing Kegels]

I’m doing my Kegels are you?
I'm doing my Kegels are you?

**Prolapse Symptoms:**

<table>
<thead>
<tr>
<th></th>
<th>Not Present</th>
<th>Not at All</th>
<th>Somewhat</th>
<th>Moderately</th>
<th>Quite a Bit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do you usually experience pressure in the lower abdomen?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td>Do you usually experience heaviness or dullness in the pelvic area?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3</td>
<td>Do you <strong>SEE</strong> or <strong>FEEL</strong> a bulge in your vaginal area?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4</td>
<td>Do you have to push on the bulge to help you urinate or around your rectum to have/complete a bowel movement?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5</td>
<td>Do you usually experience a feeling of incomplete bladder emptying?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6</td>
<td>Do you ever have to push a bulge in your vaginal area with fingers to start/complete urination?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Colorectal Anal Distress Symptoms:**

<table>
<thead>
<tr>
<th></th>
<th>Not Present</th>
<th>Not at All</th>
<th>Somewhat</th>
<th>Moderately</th>
<th>Quite a Bit</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Do you feel you need to strain too hard to have bowel movement?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8</td>
<td>Do you feel you haven’t completely emptied bowels at the end of the bowel movement?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9</td>
<td>Do you usually lose stool beyond your control if your stool is well formed?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10</td>
<td>Do you usually lose stool beyond your control if your stool is loose?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11</td>
<td>Do you usually lose gas from the rectum beyond your control?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>12</td>
<td>Do you usually have pain when you pass your stool?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>13</td>
<td>Do you experience a strong sense of urgency and must rush o the bathroom for a bowel movement?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>14</td>
<td>Does part of the bowl ever pass through the rectum and bulge outside during/after a bowel movement?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15</td>
<td>How often do you have a bowel movement?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pelvic Organ Prolapse Distress Inventory:**

<table>
<thead>
<tr>
<th></th>
<th>Not Present</th>
<th>Not at All</th>
<th>Somewhat</th>
<th>Moderately</th>
<th>Quite a Bit</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Do you usually experience pressure in the lower abdomen?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>17</td>
<td>Do you usually experience heaviness or dullness in the pelvic area?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>18</td>
<td>Do you <strong>SEE</strong> or <strong>FEEL</strong> a bulge in your vaginal area?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>19</td>
<td>Do you have to push on the bulge to help you urinate or around your rectum to have/complete a bowel movement?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>20</td>
<td>Do you usually experience a feeling of incomplete bladder emptying?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>21</td>
<td>Do you ever have to push a bulge in your vaginal area with fingers to start/complete urination?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

I’m doing my Kegels are you?
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you usually experience frequent urination?</td>
<td>☐    ☐    ☐    ☐    ☐    ☐</td>
</tr>
<tr>
<td>Do you usually experience urine leakage associated with the feeling of urgency?</td>
<td>☐    ☐    ☐    ☐    ☐    ☐</td>
</tr>
<tr>
<td>Do any of these activities cause you to leak?</td>
<td>☐ Coughing ☐ Sneezing ☐ Laughing ☐ Lifting heavy objects ☐ Exercise ☐ Movement</td>
</tr>
<tr>
<td>Do you usually experience small amounts of urine leakage (that is, drops)?</td>
<td>☐    ☐    ☐    ☐    ☐    ☐</td>
</tr>
<tr>
<td>Do you usually experience difficulty emptying your bladder?</td>
<td>☐    ☐    ☐    ☐    ☐    ☐</td>
</tr>
<tr>
<td>Do you usually experience pain or discomfort in the lower abdomen or genital region?</td>
<td>☐    ☐    ☐    ☐    ☐    ☐</td>
</tr>
<tr>
<td>If you urinate, how long can you wait before you feel like you must urinate again?</td>
<td>Less than 30 minutes</td>
</tr>
<tr>
<td>How many times do you get up at night because you feel like you must urinate?</td>
<td>1 time</td>
</tr>
<tr>
<td>How often do you have the inability to control urination?</td>
<td>Everyday/every night</td>
</tr>
<tr>
<td>How much urine are you leaking?</td>
<td>None</td>
</tr>
<tr>
<td>How often do you have the inability to control urination?</td>
<td>Everyday/every night</td>
</tr>
<tr>
<td>How much urine are you leaking?</td>
<td>None</td>
</tr>
<tr>
<td>How often do you have an inability to control urination?</td>
<td>Everyday/every night</td>
</tr>
<tr>
<td>What forms of protection do you use to counter the leaking? (check all that apply)</td>
<td>☐ Incontinence pads ☐ Panty liners ☐ Absorbent underwear (Thinx) ☐ Not applicable ☐ Diapers ☐ Tissue paper ☐ None ☐ Other: ____________</td>
</tr>
<tr>
<td>How many do you typically use? _______ Per Day OR _______ Per Week</td>
<td></td>
</tr>
</tbody>
</table>

**Interpersonal History:**

**Relationship status: (check all that apply)**

- ☐ Married  ☐ Not in a relationship  ☐ Widowed  ☐ Other: ____________
- ☐ Partner  ☐ Divorced  ☐ Other: ____________

Are you currently sexually active?  ☐ Yes  ☐ No
If Yes, with whom?  ☐ Male  ☐ Female  ☐ Both

Are you having any of the following sexual problems? (check all that apply):

- ☐ Pain with sex  ☐ Incompatibility with partner  ☐ Decreased/absent arousal  ☐ Partner Sexual Dysfunction  ☐ Low libido  ☐ Vaginal Dryness  ☐ Lack of orgasm  ☐ Other: ____________

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

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CU also offers a Sexual Women’s Health Clinic and we would be happy to refer you too if that is of interest. For more information on this clinic use the link: https://obgyn.coloradowomenshealth.com/services/clinics/womens-sexual-health-services

Dietary (Average cups/day):

- Water: ___________ cups
- Coffee: ___________ cups
- Tea: ___________ cups
- Soda/carbonated beverages: ___________ cups
- Citric beverages: ___________ cups
- Alcohol: ___________ drink(s)
- Spicy Foods: ___________ times a week

We suggest going into MyChart to update your chart before you visit to ensure we have the most up to date information. This will give us the ability to focus more on your current symptoms rather than going back into your history. If you have updated your MyChart it is not necessary to fill out the following boxed portion. If you are a new patient or need to revise your history, please answer the boxed questions on pages 4-7 OR log into your MyChart. If you are a new patient visit this website to get started. https://www.uchealth.org/access-my-health-connection/

Medical History:

(Please check all conditions that apply to you)

☐ Arthritis
☐ Asthma/COPD
☐ Blood clots
☐ Blood Transfusion
☐ Connective Tissue Disorder
☐ Depression or Anxiety
☐ Diabetes
☐ DDD/ 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
☐ Cancer: (type ___________)

Other conditions not listed or details from those checked off:

__________________________________________________________________________________

__________________________________________________________________________________

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

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

I’m doing my Kegels are you?
I’m doing my Kegels are you?

Medications: (if you take more than four medications then please log on to my health connection to update the information)

Please bring a list of your medication if you need more room

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

Do you take aspirin, ibuprofen, coumadin or any other blood thinners on a regular basis? ☐ No ☐ Yes
If yes, what do you take: __________________________

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 (☐ L ☐ R) ☐ Both removed

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______ ☐ Bladder BOTOX _________

Have you had any other gynecologic (female) surgeries other than those you have already listed? 
☐ No ☐ Yes Date: ______
If yes, type of surgery: ________________________________________________________________

If you have had prior prolapse or incontinence surgery please request that those records be sent to our office and bring copies of the operative notes if you don’t have them please sign the attached release of records form so we can obtain them

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

<table>
<thead>
<tr>
<th>Date (month/year)</th>
<th>Surgical Procedure</th>
<th>Surgeon</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Did you experience problems with anesthesia with any of these surgeries?  ☐ No  ☐ Yes
If yes, please describe what happened: ________________________________________________________

Family History of a pelvic floor disorder:

Do you have any family history of Incontinence or Pelvic organ prolapse?  ☐ Yes  ☐ No  ☐ Unknown
If so, who in your family has or has had these symptoms? (Check all that apply)
☐ Mother  ☐ Sibling  ☐ Father  ☐ Grandparent  ☐ N/A

Health Habits:

Do you, or have you ever used any of the following drugs? (Check all that apply)
☐ Heroin  ☐ Methamphetamines  ☐ Medical Marijuana  ☐ Recreational Marijuana
☐ Cocaine  ☐ IV (Intravenous)
☐ Tobacco: ☐ Former smoker  ☐ Current sometimes  ☐ Current everyday smoker

How often do you have a drink containing alcohol:  ☐ Never  ☐ Monthly or less  ☐ 2-4 times a month
☐ 2-3 times a week  ☐ 4 times or more a week

How many drinks a day/week:  ☐ 1-2  ☐ 3-4  ☐ 5 or more  ☐ None  ☐ Other: __________

Gynecologic History: Are you post-menopausal?

<table>
<thead>
<tr>
<th>☐ No- if no please answer the following questions</th>
<th>☐ Yes-if yes please answer the following questions</th>
</tr>
</thead>
</table>
| What do you use to prevent pregnancy?  ☐ Pill/Patch/Ring ☐ Depo-Provera ☐ IUD
☐ Barrier method ☐ Tubal Ligation
☐ Vasectomy
☐ Surgical Menopause?
☐ Hysterectomy ☐ Ovary removal
☐ Other: ___________________________ | Have you experienced any post-menopausal vaginal bleeding?  ☐ Yes  ☐ No
What type of hormone are you taking?
☐ Estrogen ☐ Progesterone ☐ Testosterone
☐ Other: ___________________________
Check any of the following hormones you are currently taking:
☐ Oral ☐ Patch ☐ Vaginal ☐ Sublingual ☐ Injectable

Lifestyle/physical activity (per week):
What exercise activity do you do? (Check all that apply)
☐ Aerobic (jogging, walking)  ☐ Flexibility (yoga, light stretches)

I’m doing my Kegels are you?
☐ Strength (lifting weights, resistance machines)      ☐ Balance (standing on one foot, heel-toe walking)

How many days do you exercise a week on average? ________________________ days

How many minutes do you exercise a week on average? ____________________ minutes

Do you have urine leakage when exercising? □ Yes □ No

Obstetric History:

Total number of times you have been pregnant: _____________

How many vaginal deliveries have you had? _____________

  What was the weight of your largest baby vaginal delivery? _______ lbs. _________ oz.

How many c-sections have you had? _____________

  What was the weight of your largest baby through c section? _______ lbs. _________ oz.

Were forceps (metal spoons) used during delivery? □ Yes □ No □ I don’t remember

Was a vacuum (suction) used during delivery? □ Yes □ No □ I don’t remember

Did you have an episiotomy or any tares? □ Yes □ No □ I don’t remember

If yes, was there any tearing in the anus or sphincter? (3rd or 4th degree) □ Yes □ No

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

I’m doing my Kegels are you?