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Health Questionnaire

Name _____Age_____ Marital Status _____Date _____

Birth Place _____Date of Birth _____

Please briefly summarize your urinary or pelvic floor problems(s):_____
_____
_____
_____
_____
_____

Please list any **allergies or sensitivities** to medicine._____
(IF No allergies please write "NONE")_____

Medical Information

Please check the appropriate box if you have a history of any of the following:

NEUROLOGICAL DISEASE	□	CHOLESTEROL	□
ASTHMA	□	KIDNEY STONES	□
KIDNEY INFECTIONS	□	LIVER DISEASE	□
CANCER	□	PSYCHIATRIC DISEASE	□
GASTROINTESTINAL DISEASE	□	BLOOD TRANSFUSIONS	□
DIABETES	□	HEART TROUBLE	□
HIGH BLOOD PRESSURE	□	LUNG DISEASE	□
URINARY TRACT INFECTIONS	□	THYROID DISEASE	□
PELVIC RADIATION	□	CHILDHOOD BEDWETTING	□
ALLERGY TO ADHESIVE TAPE	□	ALLERGY TO LATEX	□
EASY BRUISING OR BLEEDING	□		

OTHER MEDICAL ILLNESS (please explain):

_____
_____
_____
_____
_____
_____

Name _____

MENSTRUAL AND OBSTETRICAL HISTORY

AGE FIRST STARTED_____ ARE YOU REGULAR? _____
FLOW: HEAVY MEDIUM LIGHT

LAST MENSTRUAL PERIOD DATE_____ DATE OF LAST PELVIC EXAM_____

DATE OF LAST PAP TEST_____ BIRTH CONTROL METHOD_____
RESULTS : NEGATIVE POSITIVE

ARE YOU ON HORMONE REPLACEMENT THERAPY? _____

Last Mammogram:_____ normal? Yes No
PREGNANCIES:
HOW MANY PREGNANCIES? _____
HOW MANY MISCARRIAGES?_____
HOW MANY VAGINAL BIRTHS? _____
HOW MANY CESAREAN SECTIONS?_____
PREGNANCY COMPLICATIONS?_____

SURGICAL HISTORY

Please list all previous surgeries, including oral, C-sections or previous plastic surgery:

Operation	Year	Hospital	Surgeon's Name

*Add a separate sheet if necessary.

FAMILY HISTORY:

HIGH BLOOD PRESSURE □ HEART DISEASE □ COLON CANCER □
DIABETES □ BREAST CANCER □ OVARIAN CANCER □
KIDNEY DISEASE □ INCONTINENCE □
OTHER_____

SOCIAL HISTORY:
Do you smoke? _____ How much/How long? _____

Do you drink alcoholic beverages? _____ How much? _____

What do you do for work? _____

Do you exercise regularly? _____ If so, what kind? _____
How often? _____

Name _____

MEDICATIONS: Please list all medicines you are now taking, and how often you take them, including birth control pills, diuretics (water pills), blood pressure or heart medicine, tranquilizers, hormones, aspirin, cortisone, diabetic medicine, blood thinners, or anticoagulants.

Medicine	Strength	Frequency

Do you have any of the following symptoms today? If yes, please mark.

FREQUENT OR SEVERE HEADACHES ____ FAINTING SPELLS ____ DIZZINESS ON CHANGE OF POSITION ____ DOUBLE VISION ____ SPOTS BEFORE EYES ___ WEAR GLASSES ____ EAR ACHES ____ RECURRENT NOSE BLEEDS ____ SINUS TROUBLE ____ HAY FEVER ____ BACKACHES ____ JOINT PAINS ____ SWELLING OF ANY JOINTS ____ REDNESS OF ANY JOINTS ____ TINGLING OR WEAKNESS OF HANDS OR FEET ____ MUSCLE SPASMS ____ LOSS OR CHANGE IN SENSATION OF HANDS OR FEET ____ TREMBLING OF ANY EXTREMITY ____ RECURRENT SORES IN MOUTH ____ CHEST PAIN ____ COUGHING UP BLOOD ____ NIGHT SWEATS ____ CHRONIC OR FREQUENT COUGH ____ WAKE UP AT NIGHT SHORT OF BREATH ____	SWELLINGS OF HANDS, FEET, OR ANKLES ____ PALPITATIONS OR FLUTTERING OF HEART ____ LEG CRAMPS ON WALKING OR AT NIGHT ____ ENLARGED VEINS IN LEG ____ ABDOMINAL CRAMPING _____ NAUSEA OR VOMITING ____ VOMITING BLOOD ____ BELCHING OR HEART BURN ____ DO YOU AVOID SOME FOODS ____ WHAT KINDS? _____ AVOID SPICES ____ ANY BLOOD IN BOWEL MOVEMENT ____ RECTAL PAIN WITH BOWEL MOVEMENT ____ COLOR OF BOWEL MOVEMENT? _____ CHANGE IN SIZE, SHAPE, OR TEXTURE OF BOWEL MOVEMENT ____EXPLAIN_____ BRITTLENESS OF NAILS ____ DRYNESS OF SKIN ____ EASY BRUISING ____ INABILITY TO STAND HEAT ____ INABILITY TO STAND COLD ____ CHANGE IN HAIR TEXTURE ____ CHANGE IN SKIN TEXTURE ____ ANY SKIN RASH ____ OTHER SYMPTOM_____

Patient Signature:_____ ____ **Date:_____**

Physician Signature:_____ **Date:_____**