



UNC
HEALTH CARE

Catherine Matthews, MD, Division Chief

Ellen C. Wells, MD

Anna Marie Connolly, MD

Mary Jannelli, MD

Elizabeth Geller, MD

Brent Parnell, MD

Barbara Robinson, MD

Andrea Crane, MD

We are looking forward to your upcoming visit with the UNC Specialty Women's Center at Rex Hospital.



In order to facilitate your visit, please complete the following forms before your scheduled appointment. These forms will be collected at check-in.

If you have any questions prior to your visit, please contact our office at the number listed below.

Nurse Line (919) 784-6576

Scheduling (919) 784-6425

Division of Urogynecology & Reconstructive Pelvic Surgery



Date _____ Age _____

Last Name _____ First Name _____ DOB _____

Referring Physician:

Primary Care Physician:

Name _____

Name _____

Address _____

Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Today's Visit:

What is the main reason you came to the office today?

When did it start? _____

What treatments have you had so far for this health issue?

Medical History:

Please list any and all current medical conditions you may have:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

Please list any past surgeries and date:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Please list any allergies (food, medications, etc.) and your reaction to them:

Allergy	Reaction
_____	_____
_____	_____
_____	_____

Please list or attach a list of your current medications, dose and how often you take them (*this includes birth control and hormone replacement meds*). Also include any vitamins or herbal supplements you are taking as well:

Medication	Dose	Frequency (<i>schedule</i>)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate date and place for the following procedures. If a procedure does not apply to you, select 'No'.

Procedure	Date	Result
Pap Smear <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Colonoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Past Obstetrical History:

How many times have you been pregnant? _____

Of these pregnancies, how many were...

- preterm (premature) deliveries _____
- full term deliveries _____
- miscarriages or abortions _____
- cesarean delivery _____
- forceps or vacuum _____

Weight of largest baby: _____

Past Gynecological History:

What was the first day of your last menstrual period? _____

Are you sexually active? Yes No

Please check any of the following that you currently have.

- | | |
|--|--|
| <input type="checkbox"/> Heavy menstruation | <input type="checkbox"/> Fibroids (myomas) |
| <input type="checkbox"/> Irregular bleeding | <input type="checkbox"/> Sexually transmitted infection (gonorrhea, chlamydia, herpes) |
| <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Pelvic infection (PID) |
| <input type="checkbox"/> Ovarian cysts or tumors | <input type="checkbox"/> Other: _____ |

Social History:

Are you? Single Married Divorced Widowed

Who do you live with? _____

Do you work now? Yes No

What is your current or most recent job? _____

Do you exercise? Yes No

Describe your current exercise routine _____

Do you smoke? Yes No If yes, how many per day? 5 10 20 (one pack) More than 20

Would you like help to quit smoking? Yes No

How often do you drink alcohol? Daily Weekly Occasionally Never

Do you use any other drugs? Yes No Please list _____

During the past month, have you been bothered by feeling down, depressed or hopeless? Yes No

Have you ever been emotionally, physically, or sexually abused? Yes No

If yes, by whom? _____ When? _____

Family History:

Have any of your relatives had any of the following illnesses?

Diabetes Yes No Who? _____

Stroke Yes No Who? _____

Asthma Yes No Who? _____

Migraine headaches Yes No Who? _____

Hypertension Yes No Who? _____

Heart Disease Yes No Who? _____

Kidney problems Yes No Who? _____

Mental disease Yes No Who? _____

Cancer Yes No Who and what type? _____



**UNC Specialty Women's Center at Rex
UROGYNECOLOGY PATIENT QUESTIONNAIRE**

URINARY INCONTINENCE

Do you experience leakage of urine? YES / NO If yes, how long? _____ months _____ years	Do you leak urine when you cough, sneeze, or laugh? YES / NO
After you urinate, do you have dribbling? YES / NO	Do you leak urine with urgency or on the way to the bathroom? YES / NO
Please check if you leak urine during the following times:	
<input type="checkbox"/> Walking <input type="checkbox"/> Running <input type="checkbox"/> Urgency <input type="checkbox"/> Changing from sitting to standing <input type="checkbox"/> Lying down <input type="checkbox"/> Exercise <input type="checkbox"/> Straining or lifting <input type="checkbox"/> With Intercourse <input type="checkbox"/> Minimal activity	
Do you use a pad for urine leakage? YES / NO If yes, how many a day? _____	How long can you postpone emptying your bladder when you have the urge to urinate? _____ mins _____ hours
Do you ever wet the bed while sleeping? YES / NO	What amount of leakage do you experience? <input type="checkbox"/> Drops <input type="checkbox"/> More than drops <input type="checkbox"/> Flood <input type="checkbox"/> Leak Continually

UROLOGICAL HISTORY

Number of urinary tract infections in the last year? _____	Any blood in the urine? YES / NO If yes, when?
Any kidney infections (pyelonephritis)? YES / NO	Do you find it hard to begin urinating? YES / NO
Any history of kidney stones? YES / NO If yes, then explain:	Did you have urinary problems in childhood? YES / NO
After emptying your bladder do you have the feeling that you have not finished? YES / NO	Have you ever been catheterized in order to pass urine? YES / NO
How many times do you urinate during the day? _____	How many times do you urinate during the night after you go to sleep? _____

BOWEL SYMPTOMS

Diarrhea YES / NO	Do you strain with a bowel movement? YES / NO
Constipation YES / NO	Do you push with a finger in the vagina to assist with a bowel movement? YES / NO
Laxative Use YES / NO	How often do you have a bowel movement? _____
Difficulty controlling formed stools:	
fecal soiling YES / NO	
liquid stools YES / NO	
flatus gas YES / NO	



Date _____

Please indicate whether each of the following is currently a concern for you.

General

- Yes No Excessive fatigue
- Yes No Weight loss
- Yes No Excessive thirst
- Yes No Feeling abnormally hot or cold
- Yes No Lumps or swelling

Eye, Ear, Nose & Mouth

- Yes No Hearing difficulty
- Yes No Ringing in the ear
- Yes No Change in vision
- Yes No Change in voice
- Yes No Difficulty swallowing

Breasts

- Yes No Lumps
- Yes No Tenderness
- Yes No Swelling
- Yes No Nipple discharge
- Yes No Skin changes / rash

Lungs

- Yes No Shortness of breath
- Yes No Cough
- Yes No Wheezing
- Yes No Coughing up blood

Gastrointestinal

- Yes No Poor appetite
- Yes No Frequent nausea and / or vomiting
- Yes No Heartburn
- Yes No Black, tarry stool
- Yes No Constipation
- Yes No Diarrhea
- Yes No Blood in stool

Skin

- Yes No Rashes
- Yes No Recurrent sores
- Yes No Moles that have changed in color or size
- Yes No Swollen glands
- Yes No Itching

Heart

- Yes No Chest pain
- Yes No Heart palpitations (*irregular heart beat*)
- Yes No Discomfort in chest with exercise or walking
- Yes No Difficulty breathing
- Yes No High blood pressure
- Yes No Anemia

Nervous System

- Yes No Frequent or severe headaches
- Yes No Dizziness
- Yes No Fainting (*fell out*)
- Yes No Recurrent numbness or tingling of hands / feet
- Yes No Mood swings, irritability
- Yes No Depression or anxiety

Urinary

- Yes No Pain when urinating
- Yes No Excessive urinating at night
- Yes No Bladder infections
- Yes No Leakage of urine
- Yes No Kidney stones

Gynecological

- Yes No Heavy bleeding
- Yes No Bleeding between periods
- Yes No Irregular bleeding
- Yes No Severe cramps with period
- Yes No Pelvic pain
- Yes No Sores or ulcers
- Yes No Vaginal discharge
- Yes No Foul smelling odor
- Yes No Pain after sex
- Yes No Bleeding after sex