UACC
Urology Associates
Of Cape Cod, P.C.

Women's Health Division

Office: 508-771-9550 Fax: 508-862-6358

PATIENT INFORMATION **Date:** _____

Name: _____ **DOB:** _____ **Age:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____**Reason for Visit:** _____

As a new patient we ask that you review and complete this questionnaire prior to arriving at the clinic so that we can better understand your health history. Completing this questionnaire will help us be better prepared to address your particular health needs. We look forward to meeting you.

Referring provider:
Name: _____
Phone: _____

Primary Care Provider:
Name: _____
Phone: _____

If you are cared for by a **cardiologist**, please list below:
Name: _____ Phone: _____
Please list the name and phone number of **any other doctor** you would like us to communicate with:

_____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Preferred Pharmacy Name: _____ Address: _____

MEDICAL HISTORY

Do you have any of the following conditions? **Check all that apply**.

□ Heart Disease	□ Asthma	□ Crohn's Disease	□ Multiple Sclerosis
□ High Blood Pressure	□ COPD	□ Ulcerative Colitis	□ Stroke
□ Heart Murmur	□ Emphysema	□ Diverticulitis	□ Dementia
□ Heart Attack	□ Tuberculosis	□ Liver Disease	□ Back Injury
□ Diabetes	□ Bleeding problems	□ Heartburn/reflux	□ Anesthesia Complications
□ Thyroid Disease	□ Blood clots	□ Glaucoma	□ Anxiety or Depression
□ Osteoporosis	□ Kidney Disease	□ Arthritis	□ Psychiatric Illnesses
□ Chronic Steroid Use	□ Cancer	□ Parkinson's Disease	

Please tell us more about anything that was checked above, or about any other health problems.

_____

ALLERGIES AND MEDICATIONS:

List your allergies. Please include medication, food, and environmental allergies.

_____

_____

Please list all medications: prescriptions, over the counter, vitamins, herbs, and supplements.

Drug Name	Strength	When to take	Purpose/reason

SURGICAL HISTORY

List all surgeries you have had and the approximate date:

Surgery	Date		Surgery	Date

FAMILY HISTORY

Other than yourself. Please note if your parents, siblings, children or other family members

	Family Member(s)		Family Member(s)
Blood Clots	_____	Bladder Cancer	_____
Diabetes	_____	Breast Cancer	_____
Heart Disease	_____	Colon Cancer	_____
Heart Attack	_____	Ovarian Cancer	_____
High Cholesterol	_____	Uterine Cancer	_____
High Blood Pressure	_____	Cervical Cancer	_____
Stroke	_____	Other Cancer	_____

SOCIAL HISTORY

Tobacco use: □ Never □ Past □ Current Amount _____

Alcohol use: □ Never □ Past □ Current # of drinks/week _____

Drug use: □ Never □ Past □ Current Drug of choice _____

Do you feel safe where you live? □ Yes □ No

Do you work outside the home? □ Yes □ No

Job/School: _____

Who lives in your home: _____

Do you exercise regularly? □ Yes □ No

Type of exercise: _____

Diet: □ Regular □ Special _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT URINATION:

1. How frequently do you urinate during the day? Every _____ hour(s)
2. How many times do you get up at night to urinate? _____ times
3. Do you ever wet the bed? □ Yes □ No
4. Do you feel that you empty your bladder completely when you void? □ Yes □ No
5. Do you have trouble starting your stream of urine? □ Yes □ No
6. Do you notice any change in your stream of urine? □ Yes □ No
7. Do you ever dribble urine? □ Yes □ No
8. Have you ever had blood in the urine? □ Yes □ No
9. Do you have pain with urination? □ Yes □ No
10. Have you had 3 or more UTIs in the last 12 months? □ Yes □ No
11. Do you need to wear pads for protection from leakage of urine? □ Yes □ No

    If **yes**, what type of pads and how many per day do you normally wear?

    Pantyliners: _____ per day Regular Pads: _____ per day

    Incontinence Pads: _____ per day Adult Diapers: _____ per day

12. Have you ever used medicine to control your bladder or bowels? List all that apply:

    _____

On an average day what and how much do you drink? List below:

Type of fluid (ex: coffee, water, soda, milk, etc)	**How many cups?**	**Ounces per cup**

1. Do you feel bulging or protrusion from the vaginal area? □ Yes □ No
2. Do you feel a bulge or something falling out that you can see/feel in the vaginal area? □ Yes □ No
3. Do you ever have to push on a bulge in the vaginal area with your fingers to empty your bladder? □ Yes □ No
4. Do you feel pelvic pressure? □ Yes □ No

Please answer the following questions about your bowels:

1. Do you feel the need to strain hard to have a bowel movement? □ Yes □ No
2. Do you feel you completely empty your bowels at the end of a movement? □ Yes □ No
3. Do you ever have to push on the vagina or around the rectum to have or complete a bowel movement? □ Yes □ No
4. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? □ Yes □ No
5. Do you ever accidentally loose stool? □ Yes □ No

    If yes, when (check all that apply): with liquid stool with solid stool
6. Do you ever accidentally loose gas from the rectum? □ Yes □ No
7. Do you need to wear pads? □ Yes □ No

    If yes, what type of pads and how many per day do you normally wear?

    Pantyliners: _____ per day Regular Pads: _____ per day

    Incontinence Pads: _____ per day Adult Diapers: _____ per day

OBSTETRICAL AND GYNECOLOGICAL HISTORY

OBSTETRICAL AND GYNECOLOGICAL HISTORY

1. How many times have you been pregnant? _____
2. How many children did you deliver vaginally? _____ By C-Section? _____
3. How big was your biggest baby? _____
4. Did you have any tears or an episiotomy with any of your deliveries? □ Yes □ No
5. Have you experienced menopause? □ Yes □ No

If you answered Yes:

How old were you when you went through menopause? _____
Are you taking hormone replacement?

☐ Yes (list type: _____)

☐ No

For how many years have you taken Hormone replacement? _____

Do you use vaginal estrogen? ☐ Yes ☐ No

If you answered No:

Date of last menstrual period: _____
Period comes every _____ days.
Period lasts for _____ days.
Do you have problems with your periods?

☐ Yes ☐ No

Do you use birth control?

☐ Yes (List method:

☐ No

6. Are you sexually active? □ Yes □ No
7. Is sexual intercourse painful for you? □ Yes □ No
8. Do you leak urine during intercourse? □ Yes □ No
9. In your life, have you ever been sexually or physically abused? □ Yes □ No
10. Have you ever had any sexually transmitted infections? □ Yes □ No

    If yes, which one? _____
11. Date of last Pap Smear: _____ Have you ever had an abnormal Pap Smear? □ Yes □ No
12. Date of last mammogram: _____ Have you ever had an abnormal mammogram? □ Yes □ No
13. Date of last colonoscopy or sigmoidoscopy: _____ Ever abnormal? □ Yes □ No
14. Date of last bone density scan: _____ Ever abnormal? □ Yes □ No