Seasons Center for Urogynecology & Advanced Pelvic Surgery
240 Medical Park Blvd, Ste 2700
Bristol, TN 37620
Phone: (423) 990-2450
Fax: (423) 990-2492
seasonsurogynecology.com

NEW PATIENT PACKET

Patient History

Name: _____ Date of Birth: _____ Age: _____

Who referred you? _____ Primary Care Doctor: _____

Gynecologist: _____ Cardiologist: _____

Gastroenterologist: _____

Occupation: _____ Email: _____

What are the reasons for your visit? (Check all that apply)

__ Urinary Leakage with cough/sneeze/exercise
__ Vaginal bulging or protrusion
__ Frequent urination
__ Inability to postpone urination
__ Pelvic pain
__ Bladder pain
__ Bladder infections
__ Loss of bowel control
__ Interstitial cystitis
__ Other: _____

How long has this problem bothered you?

_____

What are your expectations in seeing help for this problem?

__ Complete Cure __ Reduce severity of symptoms __ Want diagnosis __ Second Opinion

Other (Please explain): _____

Have you seen any other physicians for this problem? If yes, please list the physician and any evaluation or therapy.

_____

_____

When did this problem start? _____

What have you tried for relief? _____

What makes the problem better? _____

Does anything worsen the problem? _____

How severe is the problem now? _____

Urogynecology History

Genitourinary

1. In a typical day, how many times do you urinate? (***frequency***) _____
2. In a typical night, how many times do you awaken to urinate?: (***nocturia***) _____
3. Do you leak urine when you do not want to (***stress incontinence***)?: □ No □ Yes

   If yes, check any conditions that cause you to leak:

   3a. □ Coughing □ Sneezing □ Laughing □ Exercise □ Upon standing □ Housework □ Lifting □ Intercourse
4. In a typical day, do you experience frequent, strong urges to urinate?: (***urgency***) □ No □ Yes

   4a. *If yes, do you leak urine during these strong urges: (**urge incontinence**)* □ No □ Yes

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(Urogynecology History Continued)

5. In a typical week, do you have **difficulty emptying your bladder**? □ No □ Yes
6. Do you wear **pads**: □ No □ Yes
   6a. *If yes, how many pads do you wear per day?* _____
7. How much do you drink in a typical day? (***fluid intake***) _____
8. Please list any **overactive bladder medicines** you have tried and how long did you use them?_____

_____

Gastrointestinal

9. In a typical week, how many **bowel movements** do you have? _____
10. In a typical week, how many **laxatives** do you use? _____
11. In a typical week, do you have **difficulty having bowel movements**?: □ No □ Yes
12. In a typical week, do you **leak stool** when you do not want to?: (***fecal incontinence***) □ No □ Yes
13. In a typical week, do you **leak gas** when you do not want to?: (***flatal incontinence***) □ No □ Yes

Gynecologic

14. Do you feel that your bladder, uterus, vagina or rectum are **falling out**?: (***prolapse)*** □ No □ Yes
15. Are you currently **sexually active**? □ No □ Yes
16. Do you have any **physical problems** with sexual relations? □ No □ Yes
17. Do you have **pain** with sexual intercourse? (***dyspareunia***) □ No □ Yes

Cancer Screening

Date of last pap smear: _____/_____ Was it: normal / abnormal History of abnormal pap smears? □ No □ Yes

If abnormal or history of abnormal paps, please explain:_____

Date of last mammogram: _____/_____Was it: normal / abnormal History of abnormal mammograms? □ No □Yes

If yes, please explain:_____

Date of last colonoscopy: _____/_____ Was it: normal / abnormal History of abnormal colonoscopies? □ No □Yes

If yes, please explain:_____

Have you received a Cervical Cancer Vaccination? □ No □Yes: If yes, please give the date:_____

Allergies

(Please list any drug allergies)

Medication	Reaction	Medication	Reaction

Medications

(Please list any over the counter medications in addition to prescribed medicines)

Medication name	Dose	Frequency	Prescribing Physician

Continue on back if needed

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Past Medical History

(Please check any medical problems you were diagnosed with as an adult)

□ Heart disease	□ Heart attack	□ Asthma	□ Uterine cancer
□ High Blood Pressure	□ Stroke	□ Heart murmur	□ Ovarian cancer
□ Diabetes	□ Blood clots (DVT, etc.)	□ Thyroid disease	□ Pelvic radiation for cancer
□ COPD	□ Pulmonary embolism	□ Lupus	□ Bladder cancer

□ Cancer:_____

Serious injuries (Please explain):_____

Procedures to your cervix (Conization, LEEP, etc.). Please list procedure, reason for procedure and date of procedure:_____

_____

Other Medical Diagnoses (please list)	Date of Diagnosis	Treating Physician

Past Surgical History

(Please list any previous surgeries/operations)

Hysterectomy Date of operation:_____

Please check the type of hysterectomy □ Abdominal incision □ Laparoscopic □ Vaginal □ Supracervical

□ Both ovaries were removed □ Right ovary was removed □ Left ovary was removed

Reason for surgery:_____

Any other procedures performed during surgery:_____

Removal of ovaries as a separate surgery Date of operation:_____

Please check the type of surgery

□ Laparoscopy □ Abdominal incision □ Both ovaries were removed □ Right was removed □ Left was removed

Reason for surgery:_____

Any other procedures performed during surgery:_____

Other Gynecologic surgeries

□ Tubal ligation Reason and date of surgery:_____

□ Laparoscopy Reason and date of surgery: _____

□ Exploratory laparotomy Reason and date of surgery:_____

□ **Vaginal suspension** Reason and date of surgery:_____

□ **Cystocele repair** Reason and date of surgery:_____

□ **Rectocele repair** Reason and date of surgery:_____

□ **Bladder tack** Reason and date of surgery:_____

□ **Incontinence surgery**

□ Suburethral Sling Reason and date of surgery:_____

□ Burch Reason and date of surgery:_____

□ MMK Reason and date of surgery:_____

□ Collagen Reason and date of surgery:_____

□ **Other Abdominal surgeries**

□ Appendectomy Reason and date of surgery:_____

□ Gallbladder removal Reason and date of surgery:_____

□ Bowel surgery Reason and date of surgery:_____

Other Surgeries or Hospitalizations (Please list)	Date	Hospital

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Obstetrical History

Please list number of:

Pregnancies (All pregnancies)_____ Miscarriages_____ Abortions_____ Living Children_____

No	Birth Date	Birth Weight	Male/Female	Weeks/Months of pregnancy	Type of Delivery	Tears into Rectum N/Y
1	__/__/__	_____	M / F	_____weeks / months	Vaginal / C/section / Vacuum / Forceps	□ No □Yes
2	__/__/__	_____	M / F	_____weeks / months	Vaginal / C/section / Vacuum / Forceps	□ No □Yes
3	__/__/__	_____	M / F	_____weeks / months	Vaginal / C/section / Vacuum / Forceps	□ No □Yes
4	__/__/__	_____	M / F	_____weeks / months	Vaginal / C/section / Vacuum / Forceps	□ No □Yes
5	__/__/__	_____	M / F	_____weeks / months	Vaginal / C/section / Vacuum / Forceps	□ No □Yes
6	__/__/__	_____	M / F	_____weeks / months	Vaginal / C/section / Vacuum / Forceps	□ No □Yes

(Continue on back if needed)

Gynecologic History

Menstrual History

How old were you when you had your first period?_____
Age of menopause (if applicable):_____
If abnormal cycles, please explain:_____

First day of last menstrual cycle: _____/_____/_____
How often do you have a menstrual cycle:_____
Length of bleeding:_____

Sexual History

If you are sexually active, what birth control (if any) do you use?: □ None □ Pill □Patch or ring □ Depo Provera (shot)
□ IUD □ Condoms □ Rhythm method □ Tubal ligation □ Partner has vasectomy □ Other _____
History of sexually transmitted diseases?: □ No □Yes If yes, please explain:_____

Social History

1. Do you smoke currently? □ No □Yes If yes:_____# packs per day for_____years
2. Did you smoke in the past? □ No □Yes If yes, when did you quit?_____
3. Do you drink alcohol? □ No □Yes If yes, how much:_____
4. Do you use any street drugs? □ No □Yes If yes, please explain:_____
5. Do you exercise regularly? □ No □Yes If yes, please describe:_____
6. Do you drink caffeine? □ No □Yes If yes, please describe:_____

Family History.

Has anyone in your family had any of these diseases? If so, please give relationship to you.

1. Breast cancer:_____ 2. Heart disease:_____
3. Ovarian cancer:_____ 4. Colon cancer:_____
5. Prolapse (including cystocele or rectocele):_____
6. Urinary Incontinence:_____
7. Other disease(s), please list:_____

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Review of Systems

In the past **7 days**, have you been bothered by any of the symptoms below?

Constitutional:	□ Fever □ Loss of appetite	□ Fatigue	□ Weight change
Eyes:	□ Eye pain	□ Blurry vision	□ Loss of vision
ENMT:	□ Swollen neck glands	□ Loss of hearing	
Cardiovascular:	□ Chest pain □ Fainting (syncope)	□ Heart palpitations □ Heart murmur	□ Leg swelling
Respiratory:	□ Shortness of breath	□ Wheezing	□ Frequent coughing
Gastrointestinal:	□ Abdominal pain □ Blood in stool □ Decreased appetite	□ Constipation □ Vomiting	□ Diarrhea □ Nausea
Genitourinary:	□ Abnormally heavy bleeding □ Painful intercourse □ Urinary urgency □ Painful urination		□ Irregular menstrual cycles □ Abnormal discharge □ Urinary frequency □ Blood in urine
Musculoskeletal:	□ Joint pain □ Difficulty walking	□ Joint stiffness □ Muscle pain	□ Back pain □ Muscle weakness
Neurological:	□ Frequent headaches	□ Frequent dizziness	□ Seizures
Skin:	□ Rash	□ Itching	
Breast:	□ Breast mass	□ Breast pain	□ Nipple discharge
Psychiatric:	□ Depression	□ Anxiety	□ Memory loss or confusion
Endocrine:	□ Diabetes	□ Hyperthyroidism	□ Hypothyroidism

Patient signature _____ Date _____

Physician signature (Above information was reviewed) _____ Date _____

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SF-12 ®

This information will help your doctors keep track of how you feel and how well you are able to do your usual activities. Answer every question by placing a check mark on the line in front of the appropriate answer. If you are unsure about how to answer a question, please give the best answer you can and make a written comment beside your answer.

1. In general, would you say your health is:
_____Excellent (1)
_____ Very Good (2)
_____ Good (3)
_____ Fair (4)
_____ Poor (5)

The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?

2. MODERATE ACTIVITIES, such as moving table, pushing a vacuum cleaner, bowling, or playing golf:
_____Yes, Limited A Lot (1)

_____Yes, Limited A Little (2)

_____ No, Not Limited At All (3)

3. Climbing SEVERAL flights of stairs a

_____Yes, Limited A Lot (1)

_____ Yes, Limited A Little (2)

_____ No, Not Limited At All (3)

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

4. ACCOMPLISHED LESS than you would like:

_____ Yes (1)

_____ No (2)

5. Were limited in the KIND of work or other activities:

_____ Yes (1)

_____ No (2)

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

6. ACCOMPLISHED LESS than you would like:

_____ Yes (1)

_____ No (2)

7. Didn't do work or other activities as CAREFULLY as usual:

_____ Yes (1)

_____ No (2)

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8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?
_____ Not at all (1)
_____ A Little bit (2)
_____ Moderately (3)
_____ Quite a bit (4)
_____ Extremely (5)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS –

9. Have you felt calm and peaceful?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

10. Did you have a lot of energy?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

11. Have you felt downhearted and blue?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

12. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

Total Score: _____ _____Pre op _____Post op 2-3wk _____6 month post _____1 yr. post