SLUCare®
The Physicians of
Saint Louis University

Urogynecology and Pelvic Reconstructive Surgery
Medical History Questionnaire

Name: _____ **Birth date**: ___/___/___ **Date form filled**: ___/___/___

Name of Referring Physician: _____

Name of Primary Care Physician: _____

In your own words, describe why you have been asked to come here:

_____

_____

_____

_____

_____

Problem	**Yes**	**No**
Do you leak urine with coughing, sneezing, laughing, etc?		
Do you leak urine trying to get to the bathroom in time?		
Do you urinate too frequently?		
Do you wake up at night to urinate?		
Is it hard to empty your bladder?		
Is constipation a problem?		
Do you lose bowel movements or gas by accident?		
Is there pressure in your bottom, or a bulge of your female organs?		
Do you have a lot of bladder or urinary infections?		

Allergies: Please list them with the kind of reaction you get below.			
Medication name	Reaction	Medication name	Reaction

Medications: Please list names, doses and how often taken		
Medication name	Dose	How often taken

MEDICAL PROBLEMS: Please circle Yes or No.								
Abnormal pap	Y	N	Anemia	Y	N	Anesthetic complications	Y	N
Arthritis	Y	N	Asthma	Y	N	Bladder/Kidney infections	Y	N
Cancer	Y	N	Cataract	Y	N	Chlamydia	Y	N
Crohn's disease/ Ulcerative colitis	Y	N	Congenital heart disease	Y	N	Congestive heart failure	Y	N
Depression	Y	N	DVT (blood clots)	Y	N	Emphysema/COPD	Y	N
Epilepsy/Seizures	Y	N	Fibromyalgia	Y	N	Gestational diabetes	Y	N
Glaucoma	Y	N	Gonorrhea	Y	N	Heart attack	Y	N
Murmur	Y	N	Heart problems	Y	N	Viral hepatitis	Y	N
Heartburn/GERD	Y	N	Herpes	Y	N	HIV/AIDS	Y	N
HPV	Y	N	Hypertension	Y	N	Irritable bowel syndrome	Y	N
Interstitial cystitis	Y	N	Kidney disease	Y	N	Kidney stones	Y	N
Migraines	Y	N	Osteoporosis/penia	Y	N	Pulmonary embolus	Y	N
Sickle cell trait	Y	N	Sickle cell disease	Y	N	Stroke	Y	N
Syphilis	Y	N	Thyroid disease	Y	N	Trichomonas	Y	N
Tuberculosis	Y	N	Type I diabetes	Y	N	Type II diabetes	Y	N

Other medical problems (please list if not mentioned above)

_____

_____

_____

SURGICAL HISTORY:								
Appendectomy	Y	N	Ovaries and tubes removed (both)	Y	N	Cervical biopsy	Y	N
Cervical cerclage	Y	N	Gallbladder removed	Y	N	Cervical cone biopsy	Y	N
C-Section	Y	N	D&C	Y	N	Heart bypass surgery	Y	N
Hernia repair	Y	N	Hysteroscopy	Y	N	LEEP	Y	N
Mastectomy	Y	N	Single ovary removed	Y	N	Ovarian cyst removed	Y	N
Tonsillectomy	Y	N	Abdominal hysterectomy	Y	N	Vaginal hysterectomy	Y	N
Tubal ligation	Y	N	Vulvar biopsy	Y	N			

Other surgery (please list below if not mentioned above)

_____

_____

FAMILY HISTORY: what have your family members suffered from medically?	
Medical problem	**Which relative(s) had this?**
Diabetes	
Breast cancer	
Ovarian cancer	
Colon cancer	
Osteoporosis	
Heart disease	
Hypertension	
High cholesterol	
Deep vein clot	
Clot in lung	
Depression	
Endometriosis	
Interstitial cystitis	
Vulvodynia	

SOCIAL HISTORY: please tell me about your habits.

Tobacco use: Please check appropriate box

	I currently smoke [ ] pack(s) a day, and have smoked for [ ] years
	I have never smoked
	I used to smoke, but quit in [ ]
	I have only been exposed to passive smoke (others smoke, but not me)

Alcohol use: Please check appropriate box

	I currently use alcohol, and drink about [ ] drinks a week
	I do not drink alcohol

Street drug use: Yes, No If yes, I use _____
Sexually active: Yes, No
Birth control used: None If yes, I use _____

Total Pregnancies _____ Number of deliveries _____ Number living children _____
Weight of largest baby born vaginally _____
Number of deliveries using forceps ____ using vacuum _____
Torn into rectum during delivery of baby(s) _____

Occupation: (retired) _____
Last Pap smear: Date: _____ Normal , Abnormal _____
Last mammogram: Date: _____ Normal, Abnormal _____

REVIEW OF SYSTEMS: Please tell me if you suffer from these conditions.
Please **CIRCLE** if these apply to you, if not, please circle (none) at the end of the line

Constitutional: Fever, chills, sweats, fatigue, malaise, anorexia, weight loss _____(none)

Eyes: contacts/glasses, cataracts, glaucoma, visual disturbance, irritation, redness, yellow in eyes, color blindness_____(none)

Head and neck: hearing loss, ringing in ears, ear drainage, earache, nasal congestion, bloody noses, snoring, sore mouth, sore throat, hoarseness, voice changes _____(none)

Breathing: cough, sputum, coughing up blood, pleurisy, pneumonia, asthma, wheezing, shortness of breath on exertion, emphysema _____(none)

Heart and circulation: chest pain, chest discomfort, shortness of breath, palpitations, irregular heart beat, near-fainting, fainting, fatigue _____(none)

Intestinal: difficulty swallowing, painful swallowing, reflux/heartburn, nausea, vomiting, change in bowel habits, black or bloody stool _____(none)

Genitourinary: frequent urination, painful urination, waking up to urinate at night, leaking urine, difficulty starting to urinate, decreased stream, blood in urine_____(none)

Skin /breast: rash, skin lesions, itching, dryness, skin color change, change in a mole, breast lump, nipple discharge _____(none)

Blood: easy bruising, bleeding easily, swollen glands, broke blood vessels on skin _____(none)

Muscles: pain in muscles, joint pain, still joints, neck pain, back pain, muscle weakness, bone pain _____(none)

Nerves: headache, dizziness, seizures, memory problems, speech problems, tingling, coordination problems, difficult walking, tremor, weakness _____(none)

Psychiatric: abusive relationship, ADHD, aggressive behavior, anorexia, anxiety, bad moods, behavior problems, bipolar, borderline personality, depression, alcoholism _____(none)

Glands: diabetes, fertility problems, temperature intolerances _____ (none)

Allergy: rashes, hay fever, angioedema, anaphylaxis _____(none)