INITIAL HISTORY AND PHYSICAL – FEMALE RENAISSANCE WOMEN'S HEALTHCARE

Patient Name _____ Medical Record # _____

Date _____ Age _____ Phone _____

Name of Referring Doctor _____ Self Referred YES NO

Chief Complaint _____
_____
_____

BLADDER SYMPTOM QUESTIONAIRE (circle symptoms that are present now)
How often do you urinate: during the day? _____ during the night? _____
Is the amount of urine you usually pass: LARGE AVERAGE SMALL
Do you have difficulty starting your urinary flow?.....YES NO
Do you strain to void your urine?.....YES NO
Is your urine flow (circle one) Strong Weak Dribbling Intermittent
Do you feel that you empty your bladder completely? .....YES NO
Do you notice dribbling of urine after voiding?.....YES NO
Do you have to assume abnormal positions to urinate?.....YES NO
Do you lose urine (incontinence)?.....YES NO
Duration of incontinence? _____Months _____Years
Is it caused by activities such as coughing, laughing, running, playing sports, etc?....YES NO
Do you need to wear protective 'pads' for **this** type of incontinence?.....YES NO
Are you bothered by a strong sense of urgency to void?.....YES NO
Can you overcome the sensation of urgency to void?.....YES NO
Do you sometimes not make it to the bathroom in time (urgency incontinence)?.....YES NO
What activities seem to cause you to **unexpectedly** lose control of your urine?
- sight, sound, or feel of running water.....YES NO
- standing up after being seated or lying down.....YES NO
- "key in door" when you return home.....YES NO

Do you lose your urine during intercourse.....YES NO
If yes - with deep penetration.....YES NO
- with orgasm.....YES NO

Do you lose urine without any warning (with out activity or feeling urgency to urinate)? .....YES NO
When urinating, can you usually stop your stream?.....YES NO
Do you ever wet the bed while asleep?.....YES NO
Would you describe the amount of urine that you leak as being (you may answer more than one)
- frequent small volumes.....YES NO
- unconscious/continuous loss (always damp or wet).....YES NO
- infrequent but single large volumes of loss.....YES NO

How many pads do you usually use per day for protection? (circle choice) 1,2,3,4,5,6,7,8,more.
Has urine leakage limited your ability to: not at all min mild mod greatly
- do household chores (cooking, house-cleaning, laundry)?.....0 1 2 3 4
- physical recreation such as walking, swimming, or other exercise?...0 1 2 3 4
- participate in activities (church, movies, concerts)?.....0 1 2 3 4
- travel more than 30 minutes from home?.....0 1 2 3 4
- participate in social activities outside of your home?.....0 1 2 3 4
- participate in, enjoy, or feel comfortable with sexual activites?.....0 1 2 3 4

Do you have reduced self esteem, depression, frustration, or nervousness?
Do you have frequent urinary infections?.....YES NO
How often have these occurred in recent years? 1,2,3,4 or more per year. (circle your answer)
Do you ever see blood in your urine?.....YES NO
Do you have pain during urination?.....YES NO
Do you have pain in the lower abdomen?.....YES NO
Is the pain related to: -your bladder being full? YES NO
-your menstrual cycle? YES NO
-intercourse? YES NO
-bowel movements? YES NO