WOMEN'S PELVIC HEALTH INSTITUTE

PETER CASTILLO MD, FACOG

Patient Name:_____

Date: _____ DOB: _____

New Patient Questionnaire

CHIEF COMPLAINT:

Please briefly describe the reason(s) that you are being seen in our office:

_____

_____

How long have your experienced each problem?

_____

How did you hear about our services? Which websites did you visit?

_____

_____

Please list any previous tests or treatments for each condition

_____

_____

_____

PAST MEDICAL HISTORY:

Have you ever had any of the following problems? Please circle Yes or No		Explain
Yes / No	Bleeding Problems (Blood clots, anemia, Past transfusions)	_____
Yes / No	Cancer	_____
Yes / No	Diabetes	_____
Yes / No	Eye disorder (glaucoma, chronic dryness)	_____
Yes / No	Neurologic problems (seizures, migraines, stroke, fibromyalgia)	_____
Yes / No	Gastrointestimal disorders (ulcers, reflux)	_____
Yes / No	Heart problems (irregular heart beat, Murmur)	_____
Yes / No	Hernia	_____
Yes / No	High blood pressure	_____
Yes / No	Kidney problems (stones, infection, decreased function)	_____
Yes / No	Liver Problems	_____
Yes / No	Musculoskeletal problems (osteoarthritis, loose joints)	_____
Yes / No	Psychiatric problems (depression, anxiety, bipolar disorder)	_____
Yes / No	Respiratory problems (asthma, COPD, emphysema, sleep apnea)	_____
Yes / No	Skin disorder	_____
Yes / No	Spine injury	_____
Yes / No	Thyroid disease	_____
Yes / No	Other:	_____

REVIEW OF SYSTEMS

Check any conditions present today: ☐ I have none of these problems today

Constitutional	HEENT	Cardiovascular	Respiratory
☐ Recent weight change	☐ Visual problems	☐ Chest pain	☐ Chronic cough
☐ Fever	☐ Hearing problems	☐ Varicose veins	☐ Wheezing
☐ Weakness	☐ Dry mouth	☐ Blood clots	☐ Oxygen use
☐ Other _____	☐ Other _____	☐ Other _____	☐ Other _____
Gastrointestinal	**Musculoskeletal**	**Neurological**	**Skin**
☐ Heartburn	☐ Muscle pain	☐ Paralysis	☐ Rashes
☐ Nausea/Vomiting	☐ Joint pain	☐ Numbness	☐ Sores
☐ Hemorrhoids	☐ Limited mobility	☐ Tingling	☐ Lumps
☐ Other _____	☐ Other _____	☐ Other _____	☐ Other _____
Endocrine	**Hematological**	**Immunological**	**Psychiatric**
☐ Hot flashes	☐ Easy bruising	☐ Swollen lymph nodes	☐ Depression
☐ Excessive thirst	☐ Other _____	☐ Fever	☐ Anxiety
☐ Other _____		☐ Other _____	☐ Other _____

OBESTETRICAL HISTORY

☐ Skip this section, I have never been pregnant

Number of Pregnancies: _____ Miscarriages: _____ Abortions: _____ Living Children: _____

Date	Weight	Type of Delivery			3rd/4th Degree Tear
_____	_____	☐ Vaginal	☐ Vaginal w/ forceps/vacuum	☐ C-section	Yes / No
_____	_____	☐ Vaginal	☐ Vaginal w/ forceps/vacuum	☐ C-section	Yes / No
_____	_____	☐ Vaginal	☐ Vaginal w/ forceps/vacuum	☐ C-section	Yes / No
_____	_____	☐ Vaginal	☐ Vaginal w/ forceps/vacuum	☐ C-section	Yes / No
_____	_____	☐ Vaginal	☐ Vaginal w/ forceps/vacuum	☐ C-section	Yes / No

GYNECOLOGICAL HISTORY

When was your last menstrual period? ☐ I no longer have menstrual periods for past ____ year(s) (skip to next question)

First day of last period: ___/___/___

Age at first period: ___ Number of days between periods: ___ days Duration of bleeding: _____ days

Do you bleed between periods? ☐ Yes ☐ No

Do you have heavy periods? ☐ Yes ☐ No

Have you had a hysterectomy? ☐ Yes ☐ No

If yes, ☐ abdominal ☐ vagina ☐ laparoscopic Reason for hysterectomy _____

Were your ovaries removed? ☐ Yes ☐ No If yes, which ovary(ies)? ☐ left ☐ right ☐ both

Date of last PAP smear ___/___/___ Normal? ☐ Yes ☐ No Have you ever had an abnormal PAP? ☐ Yes ☐ No

Date of last mammogram ___/___/__ Normal? ☐ Yes ☐ No

Have you had a sexually transmitted disease? ☐ Yes ☐ No If yes. please list: _____

Patient Name:_____

Date: _____ DOB: _____

SURGICAL HISTORY:

☐ Skip this section; I have never had any type of surgery

List ALL surgeries with the date, if possible. Include abdominal and plastic surgeries

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS:

☐ Skip this section; I do not take any medications

List all of the medications that you currently take, including over-the-counter medications and herbal supplements. List the dosage and how often you take it.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES:

☐ Skip this section; I have no known allergies

List any allergies along with the type of reaction you experience

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

SOCIAL HISTORY:

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separate ☐ Widowed

Living Situation ☐ Alone ☐ Family ☐ Skilled nursing facility/nursing home ☐ Other

Tobacco Use: ☐ Yes ☐ No Daily Amount: _____ ☐ Number of Years_

Alcohol Use: ☐ Yes ☐ No Daily Amount: _____

Street Drug Use: ☐ Yes ☐ No Type and Daily Amount: _____

Caffeine Use: ☐ Yes ☐ No Type and Daily Amount: _____

Abuse: ☐ Yes ☐ No Describe:_____ _____

Exercise: ☐ Yes ☐ No Type and how often: _____

FAMILY MEDICAL HISTORY:

Please circle Yes or No Relationship (ie mother, father, siblings, grandparents, aunts)

Yes / No	Bleeding disorder	_____
Yes / No	Cancer (list type)	_____
Yes / No	Diabetes	_____
Yes / No	Heart disease	_____
Yes / No	Hernia or vaginal prolapse	_____
Yes / No	Urinary problems	_____
Yes / No	Other:	_____

PROVIDERS:

	Name	City	Telephone Number
Referring Provider:	_____	_____	
Primary Care Physician:	_____	_____	
OB/GYN:	_____	_____	
Urologist:	_____	_____	
Physical Therapist	_____	_____	
G.I.	_____	_____	
Other:	_____	_____	

Patient Name:_____

Date: _____ DOB: _____

UROGYNECOLOGIC QUESTIONNAIRE:

I urinate every ___ hours during the day **At night, I get up ___ times to urinate**

Do you lose urine in spurts with laughing, sneezing, or exertion?	Yes No
What amount of urine do you lose?	Small Large Both
In what position do you lose urine?	Sitting Standing Lying do
Do you lose urine with a strong sense of urgency?	Yes No
Does the sound, sight, or fell of running water make you lose urine?	Yes No
Do you lose urine without any warning (without activity or urgency)?	Yes No
Do you wear pads or liners every day for leakage? How many pads per day?	Yes No # pads per day_
Is it difficult to get the urine stream started?	Yes No
Does your urine stream seem slow or weak?	Yes No
Do you feel that empty your bladder completely when you urinate?	Yes No
Do you have pain associated with urination?	Yes No
Do you have frequent bladder infections?	Yes No
Do you feel as if your pelvic organs are "falling down"?	Yes No
Do you feel a bulge at the opening of your vagina?	Yes No

BOWEL FUNCTION QUESTIONNAIRE

☐ Skip this section; I have no problems with my bowel function

I move my bowels ___ times per day or ___ times per week.	
Do you have difficulty emptying your rectum?	Yes No
What is the consistency of your stool when this happens?	Liquid Soft Normal Hard
Does it help to press on the inside or outside of the vagina to have bowel movement?	Yes No
Do you lose control of stool?	Yes No
What is the consistency of your stool when this happens?	Liquid Soft Normal Hard
Do you problems controlling gas?	Yes No
Do you have alternating constipation and diarrhea?	Yes No
Do you have pain with bowel movements?	Yes No
Do you ever see blood in your stools?	Yes No

COSMETIC QUESTIONNAIRE

☐ Skip this section; I have no problems with the appearance or function of my genital region

I am self-conscious about the appearance or function of my genital region	Yes No
I am unhappy with the way my vagina looks (i.e. gaping)	Yes No
I am unhappy with the way my labia look (irregular, dark, long)	Yes No
My labia rub or pull on my clothing or during sex	Yes No
I am unhappy with the appearance of my pubic area/labia majora	Yes No
I am unable to wear the type of clothing that I want	Yes No
I like more information about cosmetic vaginal surgery	Yes No

SEXUAL FUNCTION QUESTIONNAIRE

☐ Skip this section; I do not have any problems with my sexual functioning

My vagina feels loose during sex	Yes No
I have decreased sensation during sex	Yes No
I wish to enhance my pleasure with sex	Yes No
I have low desire to participate in sexual activity	Yes No
I am unable to reach orgasm	Yes No
I have significant difficulty reaching orgasm	Yes No
I have a difficult time becoming aroused during sexual activity	Yes No
I do not become sufficiently lubricated with sexual activity	Yes No
I experience pain with vaginal penetration	Yes No

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Notes: