boston pelvic health & wellness

NEW PATIENT FORM

Thank *you for taking the time to complete this paperwork. It will help us to provide you with the best possible care. Please complete this form prior to your visit and bring it with you to your appointment.*

NAME _____

Reason for visit _____

_____

Referring Doctor _____ Primary Care Doctor_____

OB History

Total number of pregnancies _____
Full term births _____
Preterm pregnancies _____
Abortions _____
Living children _____

Number of Vaginal deliveries _____
Number of C-sections _____
Number of Forceps deliveries _____
Weight of largest baby _____

GYN History

Date of Last Menstrual Period _____
How far apart (days) _____
Length of periods (days) _____
Last pap smear _____
Last mammogram _____
Menopause Yes No If yes, age _____
Any gynecological problems?
_____

Please check all that apply:

- ☐ Bladder surgery
- ☐ Prolapse surgery
- ☐ Removal of ovaries
- ☐ Hysterectomy
- ☐ Ectopic pregnancy
- ☐ Pelvic inflammatory disease
- ☐ None
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Herpes
- ☐ Genital warts
- ☐ Syphilis or HIV
- ☐ Abnormal pap

Medical History (check all that apply) ☐ None

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Asthma
- ☐ Blood clots
- ☐ Anxiety
- ☐ Depression
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Glaucoma
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Cancer, type:

Surgical History (attach list if needed) ☐ None

Operation	Year

Other Medical Problems (attach list if needed)

_____ _____ _____

_____ _____ _____

Family History

Have any of your first-degree family members (parents, siblings or children) had the following? ☐ None

	Relative		Relative
Heart disease		Breast cancer	
High blood pressure		Ovarian cancer	
High cholesterol		Colorectal cancer	
Diabetes		Other cancer	

Social History

☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Separated ☐ Widowed

Occupation _____

Sexually active ☐ Yes ☐ No How often _____

Exercise ☐ Yes ☐ No How often _____

Alcohol use ☐ Yes ☐ No Type _____ How often _____

Drug use ☐ Yes ☐ No Type _____ How often _____

Current Smoker ☐ Yes ☐ No Packs per day _____ Age started _____

Former smoker ☐ Yes ☐ No Packs per day _____ Age started _____ Age quit _____

Medications ☐ None

For more space, please attach a sheet.

Drug	Dosage/Frequency	Purpose

Allergies ☐ None

Type	Reaction

Review of Systems Have you experienced any of these symptoms within the past four weeks? ☐ None

General
- ☐ Weight loss
- ☐ Fatigue
- ☐ Fever or chills

Skin
- ☐ Rashes
- ☐ Itching
- ☐ Hair and nail changes
- ☐ Abnormal mole

Eyes
- ☐ Vision loss/changes
- ☐ Glaucoma
- ☐ Cataracts

Ears Nose Mouth
- ☐ Decreased hearing
- ☐ Mouth ulcers
- ☐ Sore throat
- ☐ Dry mouth
- ☐ Snoring

Lungs
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough frequently
- ☐ Cough up blood

Breast
- ☐ Breast lump
- ☐ Breast tenderness
- ☐ Nipple discharge

Cardiac
- ☐ Chest pain
- ☐ Heart fluttering

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Pain with swallowing
- ☐ Constipation
- ☐ Rectal bleeding

Endocrine
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Excessive water intake
- ☐ Excessive urine output

Muscuskeletal
- ☐ Joint pain
- ☐ Back pain
- ☐ Muscle weakness

Neurological
- ☐ Frequent headaches
- ☐ Passing out
- ☐ Dizziness
- ☐ Blurred vision
- ☐ Numbness

Psychiatric
- ☐ Depression
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Mood swings

Genitourinary system

Please put an X through the section below which does not apply to you.

Please answer the questions in the box if you have **ANY** problem with **urine leakage or urination**:

1. Do you usually have an urge to urinate before you leak urine? ☐ Yes ☐ No
2. Does the sound or feel of running water make you leak urine? ☐ Yes ☐ No
3. Do you leak urine when you approach your home after being out? ☐ Yes ☐ No
4. When you have an urge to urinate, can you hold your urine until you get to the bathroom?
   ☐ always ☐ most of the time ☐ sometimes ☐ never
5. Do you leak urine when you cough, sneeze, laugh or exercise? ☐ Yes ☐ No
6. Do you wet the bed when you are completely asleep? ☐ Yes ☐ No
7. Do you leak urine during sex? ☐ Yes ☐ No
8. Do you feel like you leak urine constantly? ☐ Yes ☐ No
9. Do you wear pads to protect your clothing from leakage? ☐ Yes ☐ No
   If yes, what kind? ☐ pantiliner ☐ thick pad ☐ protective undergarment
   How many pads do you use per day? _____
10. How often do you leak urine?
    ☐ none ☐ 1-2x/month ☐ 1-2x/week ☐ 1-2x/day ☐ 3-5x/day ☐ more
11. Do you have pain or burning when you urinate? ☐ Yes ☐ No
12. Do you get frequent urinary tract or bladder infections? ☐ Yes ☐ No If yes, how many in 1 year _____
13. How many times do you urinate in a 24 hour period _____
14. How many times do you wake up to urinate each night? _____
15. How many cups of fluid (8 oz) do you drink in a day? _____
16. How many cups of caffeine do you drink in a day? coffee _____
    soda _____
    tea _____

Please answer the questions in the box if you have **ANY** problem with the **vagina or bowel**:

Vagina

1. Do you experience pressure in the vagina? ☐ Yes ☐ No
2. Do you have a bulge or something falling out that you can see or feel in your vaginal area ? ☐ Yes ☐ No
3. Do you ever have to push on the vagina to start or complete urination? ☐ Yes ☐ No
4. Do you ever have to push on the vagina or around the rectum to have a bowel movement? ☐ Yes ☐ No
5. Do you experience a feeling of incomplete bladder emptying? ☐ Yes ☐ No
6. Do you have pain/discomfort during sexual activity? ☐ Yes ☐ No
   If yes, how often? ☐ always ☐ sometimes ☐ never

Bowel

1. How are your bowel movements? ☐ normal ☐ constipated ☐ diarrhea ☐ variable
2. Do you leak stool or gas accidentally during the following (check all that apply)?
   ☐ before reaching the toilet ☐ without warning ☐ without knowing ☐ with loose stools ☐ with formed stools
3. Do you strain to have a bowel movement? ☐ always ☐ most of the time ☐ sometimes ☐ never
4. Do you use laxatives or stool softeners? ☐ Yes ☐ No
5. Do you take any anti-diarrheal meds like loperamide (Imodium)? ☐ Yes ☐ No

Thank you for taking the time to complete this form!!!