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As a new patient we ask that you review and complete all parts of this questionnaire prior to your visit. You may fax it to us at (503) 494-1678 or bring it with you to your appointment. If you have seen any other provider for these problems, please arrange for those records to be faxed as well.

********** PLEASE COMPLETE THE VOIDING DIARY ON PAGE 2 & 3**********

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____

_____

Who Sent You Here? _____ Primary Doctor or Nurse _____

What is your preferred pharmacy? _____

For what condition(s) are you seeking treatment? *(Check all that apply):*

- ❑ Urinary incontinence (loss of bladder control)
- ❑ Urinary urgency
- ❑ Too frequent voiding/urinating
- ❑ Pelvic prolapse (bulge or protrusion in the vagina)
- ❑ Constipation or difficulties with bowel movements
- ❑ Anal incontinence (problem with bowel control)
- ❑ Pelvic pain
- ❑ Other (specify below)

What would you be willing to do to improve your condition? *(Check all that apply)*

- ❑ Lose weight
- ❑ Stop smoking
- ❑ Physical therapy/exercise for the pelvic floor muscles
- ❑ Lifestyle modification
- ❑ Take medication
- ❑ Have surgery
- ❑ Conservative management (treatments to specifically avoid surgery)

OC4501

What is your goal for this visit?

_____

_____

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24 HOUR VOIDING DIARY

Please complete this chart prior to your visit. Choose a 24-hour period when it is convenient for you to measure and record the following:

1. The amount of fluid you drink and type of beverage.
2. The amount of fluid you void (urinate). Use an old measuring cup or mark off ounces on an old jar or can and use that to measure. 2 tablespoons = 1 ounce.
3. The time when leakage occurred and whether or not you have an urge to void just prior to any leakage episodes.
4. The activity you are doing when you leak or feel the need to void.
5. Your awakening and bedtimes during that 24-hour period.

Below is a sample diary for your review.

Time	Fluid Intake Amount (oz)	Void Amount (oz)	Leaks or Accidents?	Strong urges to urinate?	Activity when you leaked or had an urge.
6:20 am		8 oz			awakening
7:00 am	8 oz coffee				
7:20 am		6 oz	yes	yes	washing
7:30 am	8 oz coffee				
8:00 am		8 oz			
8:45 am			yes	no	coughing

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24 HOUR VOIDING DIARY

Date: _____ Awakening time: _____ Bedtime: _____

Time	Fluid Intake Amount (oz)	Void Amount (oz)	Leaks or Accidents?	Strong urge to urinate?	Activity when you leaked or had an urge.
TOTAL	oz	oz			

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ALLERGIES

List any medications to which you are allergic **and your reaction**:

_____
_____
_____

MEDICATIONS

What medicines are you currently taking? (Please include all over the counter medicines, herbs, remedies and supplements)

Medicine Dose and time of day

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever used any of the following medicines to help control your bowels or bladder?

- ☐ Fiber Supplements
- ☐ Laxatives
- ☐ Antidiarrheal
- ☐ Stool Softeners
- ☐ Overactive Bladder Medication
- ☐ Other

OBSTETRIC/GYNECOLOGY HISTORY

Number of pregnancies _____

Number of births _____

Number of vaginal deliveries _____

Were forceps or a vacuum ever used? ☐ yes ☐ no ☐ unsure

Did you ever require stitches? ☐ yes ☐ no ☐ unsure

Have you experienced menopause? ☐ yes ☐ no

Are you taking hormone replacement? ☐ yes ☐ no

Date of last menstrual period _____

Date of last pap smear _____

Was it normal? ☐ yes ☐ no ☐ unsure

Have you ever had an abnormal pap smear? ☐ yes ☐ no ☐ unsure

Date of last colonoscopy _____

Was it normal? ☐ yes ☐ no ☐ unsure

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YOUR SAFETY

Do you feel safe in your current relationship? ☐ yes ☐ no

Is there a partner from a past relationship who is making you feel unsafe now? ☐ yes ☐ no

Have you ever been raped or forced to engage in sexual activity against your will? ☐ yes ☐ no

Have you been hit, punched or otherwise hurt by someone within the past year? ☐ yes ☐ no

MEDICAL HISTORY

❑ Diabetes	❑ Heart Disease	❑ Endometriosis	❑ Asthma	❑ Blood Clot
❑ Arthritis	❑ Heart Attack	❑ Ovarian Cyst	❑ Sleep Apnea	❑ Hearing Loss
❑ Kidney Disease	❑ Stroke	❑ Irritable Bowel	❑ Emphysema/COPD	❑ Herniated Disc
❑ Thyroid Problems	❑ Atrial Fibrillation	❑ Fibromyalgia	❑ Multiple Sclerosis	❑ Hepatitis Type _____
❑ Seasonal Allergies	❑ High Blood Pressure	❑ Crohns' Disease	❑ Myasthenia Gravis	❑ Hemorrhoids
❑ Depression	❑ Diverticulitis	❑ Cancer	❑ Bleeding Problem	❑ Anemia
❑ Glaucoma	❑ Heartburn	❑ HIV	❑ Ulcerative Colitis	❑ Heart Failure

Please list any other medical problems you have:

_____

_____

SURGICAL HISTORY

List all surgeries and the approximate date

Date

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had:	Yes	Unknown	No
Hysterectomy?	❑	❑	❑
Removal of your ovaries?	❑	❑	❑
Bladder surgery?	❑	❑	❑
Rectal surgery?	❑	❑	❑
Surgery for prolapse?	❑	❑	❑
Mesh/graft placed?	❑	❑	❑

Was the incision Abdominal, Vaginal or Laparoscopic?

_____

_____

_____

_____

_____

_____

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FAMILY MEDICAL HISTORY

Does anyone in your family have a problem with any of the following?

Check if Adopted ☐	Self	Mother	Father	Sibling	Child	Other
Problems with Anesthesia	☐	☐	☐	☐	☐	☐
Circulatory (blood clots, bleeding problems)	☐	☐	☐	☐	☐	☐
Cancer /Type? _____	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Attack or Stroke	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
None	☐	☐	☐	☐	☐	☐

LIFESTYLE

Do you currently smoke? ☐ yes ☐ no
Have you ever smoked? ☐ yes ☐ no
How many years total have you smoked? _____ How many packs a day? _____
How many glasses of beer, wine, or alcohol do you drink per day? _____
What kind of work do you do? _____
Who is your main support person? _____

What do you consider your primary racial background?

☐ American Indian/Alaska Native ☐ Asian ☐ African American

☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Do you consider your ethnicity to be Hispanic or Latino? ☐ yes ☐ no

CURRENT SYMPTOMS

Currently are you having problems with (circle)

General:	No	fevers/chills/decreased energy/weight loss/weight gain
Eyes:	No	visual disturbances/dry eyes
Ears, nose, throat (ENT):	No	sinus problems/chronic colds/headache
Cardiovascular:	No	palpitations/chest pain/swelling in legs
Respiratory:	No	shortness of breath/cough/wheezing
Gastrointestinal:	No	diarrhea/constipation/heartburn/blood in stool
Genitourinary:	No	pain with urination/blood in urine/irregular bleeding
Musculoskeletal:	No	joint pain/back pain/muscle aches
Emotional:	No	depression/anxiety/mental changes/emotional changes
Endocrine:	No	excessive thirst/hot spells/difficulty staying warm
Hematological:	No	excessive bruising/ easy bleeding/anemia

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URINARY SYMPTOMS

Do you perform Kegel exercises? ☐ Yes ☐ No ☐ Not regularly

If yes, how frequently? _____ Times per _____

How many times do you wake up at night to urinate? _____

Do you have difficulty starting urination?	☐ No	☐ Yes
Do you have to strain to urinate?	☐ No	☐ Yes
Is your urine flow weak?	☐ No	☐ Yes
Do you leak *immediately* after emptying your bladder (when you walk away from the toilet)?	☐ No	☐ Yes
Do you ever see blood in your urine?	☐ No	☐ Yes
Do you get frequent bladder infections?	☐ No	☐ Yes

How often do you experience urinary leakage?
☐ Less than once a month
☐ A few times a month
☐ A few times a week
☐ Every day and/or night

How much urine do you lose each time? ☐ Drops ☐ Small splashes ☐ More

Do you use pads for your leakage?
If yes, what kind? ☐ panty liner ☐ menstrual pad ☐ incontinence pad
How many per day? _____

Do you use pads for: ☐ urinary leakage ☐ stool leakage ☐ both

BOWEL SYMPTOMS

How many bowel movements do you have? _____ per day _____per week

Do you leak stool? ☐ yes ☐ no

Please check one box per row:

In the past month have you experienced ***accidental*** bowel leakage?

	Once a Day	2 or more Times a week	Once a week	1 to 3 Times a month	Never
Gas	☐	☐	☐	☐	☐
Mucus	☐	☐	☐	☐	☐
Liquid Stool	☐	☐	☐	☐	☐
Solid Stool	☐	☐	☐	☐	☐

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Please check the BEST response describing your symptoms:	***Does it affect you?***		***If yes, how much does it bother you?***			
Problem	**Yes**	**No**	**Not at all**	**Somewhat**	**Moderately**	**Quite a Bit**
1. Do you usually experience pressure in the lower abdomen?	☐	☐	☐	☐	☐	☐
2. Do you usually experience heaviness or dullness in the pelvic area?	☐	☐	☐	☐	☐	☐
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	☐	☐	☐	☐	☐	☐
4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?	☐	☐	☐	☐	☐	☐
5. Do you usually experience a feeling of incomplete bladder emptying?	☐	☐	☐	☐	☐	☐
6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	☐	☐	☐	☐	☐	☐
7. Do you feel you need to strain too hard to have a bowel movement?	☐	☐	☐	☐	☐	☐
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	☐	☐	☐	☐	☐	☐
9. Do you usually lose stool beyond your control if your stool is well formed?	☐	☐	☐	☐	☐	☐
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	☐	☐	☐	☐	☐	☐
11. Do you usually lose gas from the rectum beyond your control?	☐	☐	☐	☐	☐	☐
12. Do you usually have pain when you pass your stool?	☐	☐	☐	☐	☐	☐
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐	☐	☐	☐	☐	☐
14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	☐	☐	☐	☐	☐	☐
15. Do you usually experience frequent urination?	☐	☐	☐	☐	☐	☐
16. Do you usually experience urine leakage associated with a feeling of urgency, (a strong sensation of needing to go to the bathroom)?	☐	☐	☐	☐	☐	☐
17. Do you usually experience urine leakage related to coughing, sneezing or laughing?	☐	☐	☐	☐	☐	☐
18. Do you experience small amounts of urine leakage (that is, drops)?	☐	☐	☐	☐	☐	☐
19. Do you usually experience difficulty emptying your bladder?	☐	☐	☐	☐	☐	☐
20. Do you usually experience pain or discomfort in the lower abdomen or genital region?	☐	☐	☐	☐	☐	☐

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Please let us know how much of your activities, relationships, or feelings have been affected by your bladder, bowel or vaginal symptoms or conditions over the last 3 months. Please check the best response for questions #1-7 in each of the 3 columns.

How do symptoms or conditions related to the following usually affect you?		**Bladder or Urine**	**Bowel or Rectum**	**Vagina or Pelvis**
1. Ability to do household chores?	***Not at all***	☐	☐	☐
	Somewhat	☐	☐	☐
	Moderately	☐	☐	☐
	Quite a bit	☐	☐	☐
2. Ability to do physical activities such as walking, swimming, or other exercise?	***Not at all***	☐	☐	☐
	Somewhat	☐	☐	☐
	Moderately	☐	☐	☐
	Quite a bit	☐	☐	☐
3. Entertainment activities such as going to a movie or concert?	***Not at all***	☐	☐	☐
	Somewhat	☐	☐	☐
	Moderately	☐	☐	☐
	Quite a bit	☐	☐	☐
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	***Not at all***	☐	☐	☐
	Somewhat	☐	☐	☐
	Moderately	☐	☐	☐
	Quite a bit	☐	☐	☐
5. Participating in social activities outside your home?	***Not at all***	☐	☐	☐
	Somewhat	☐	☐	☐
	Moderately	☐	☐	☐
	Quite a bit	☐	☐	☐
6. Emotional health (nervousness, depression, etc.)?	***Not at all***	☐	☐	☐
	Somewhat	☐	☐	☐
	Moderately	☐	☐	☐
	Quite a bit	☐	☐	☐
7. Feeling frustrated?	***Not at all***	☐	☐	☐
	Somewhat	☐	☐	☐
	Moderately	☐	☐	☐
	Quite a bit	☐	☐	☐

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YOUR SEXUALITY: All information is strictly confidential.

If you are not sexually active, please mark the reason that best explains why:

☐ Low libido (desire) ☐ No partner ☐ Pelvic pain
☐ Partner is not able ☐ Personal choice ☐ Other

If you ARE sexually active:
When answering the following questions, please consider your sexuality over the past 6 months

1. How frequently do you feel sexual desire?
   ☐ Never ☐ Lessthan 1x/month ☐ Monthly ☐ Weekly ☐ Daily

	Never	Seldom	Sometimes	Usually	Always
2. Do you climax (have an orgasm) when having sexual intercourse with your partner?	☐	☐	☐	☐	☐
3. Do you feel sexually excited (turned on) when engaging in sexual activity with your partner?	☐	☐	☐	☐	☐
4. How satisfied are you with the variety of sexual activities in your current sex life?	☐	☐	☐	☐	☐
5. Do you feel pain during sexual intercourse?					
6. Are you incontinent of urine (leak urine) with sexual activity?	☐	☐	☐	☐	☐
7. Does fear of incontinence (either stool or urine) restrict your sexual activity?	☐	☐	☐	☐	☐
8. Do you avoid sexual intercourse because of bulging in the vagina (the bladder, rectum or vagina falling out)?	☐	☐	☐	☐	☐
9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?	☐	☐	☐	☐	☐
10. Does your partner have a problem with erections that affects your sexual activity?	☐	☐	☐	☐	☐
11. Does your partner have a problem with premature ejaculation that affects your sexual activity?	☐	☐	☐	☐	☐

12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?

☐ Much less intense ☐ Less intense ☐ Same intensity ☐ More intense ☐Much more intense