Women's Health Questionnaire

Answering the following questions will help us to manage your care better. Please complete the following form on or before your initial visit.

Name: DOB: Date:

History of present condition:

Current activity level / occupation:

Gynecological History

Menopausal state:	Endometriosis:	Fibroids:
Cysts:	Prolapse:	Hysterectomy:
Painful Intercourse:	Pelvic Pain:	Surgery:
Sexually transmitted disease:		

Obstetric History

Number of pregnancies:	Number of vaginal deliveries:
Number of cesarean sections:	
Problems with pregnancies or deliveries (explain):	

Do you now have or have you had any of the following? Please circle and indicate dates.

Urinary tract/ bladder infection	Constipation	Back pain	Diabetes
Abdominal pain	Stroke	Asthma	Allergies
Joint problems (arthritis)	Emphysema / COPD	Smoking habit	Broken bones
Multiple Sclerosis	Osteoporosis	Heart problems	Other (please list)

Medications (please list):

Women's Health Questionnaire

When did your urinary loss start? _____

Was it associated with any specific event? (childbirth, surgery, illness, menopause) _____

How has the incontinence changed over time? (same, better, worse) _____

How many times a day do you lose urine? _____

Do you lose urine or stool when you have a strong urge to go? _____

Do you lose urine with any of the following? *Please circle*

- Coughing or sneezing
- Laughing
- Lifting
- Active exercise (running, jumping)
- Minimal exercise (walking, light housework)
- Sleeping
- Running water
- Putting a key in the door
- Nervousness or increased anxiety
- Leakage unrelated to any specific cause
- Other, please explain:

Is your clothing wet:	a few drops_____	wet underwear _____	wet outer clothes ____	wet floor ____
Do you use, for protection:	sanitary pads ____	tissue paper ____	diapers ____	# used per day _____
At each change are they:	damp ____	wet ____	saturated ____	
How often do you urinate each:	day _____	night _____		
Is the volume passed:	large _____	average _____	small _____	very small _____

Do you empty your bladder frequently, before you experience the desire to pass urine just to stay dry? _____

On average, how many glasses of fluid do you drink each day? _____ How many are caffeinated? _____

How many are water? _____ Other? _____

How long can you delay going to the bathroom one you have the urge to go? _____

Do you have any trouble initiating the urine stream? _____

Can you completely stop the flow of urine while urinating? _____

How often do you have a bowel movement? _____

Do you have any bowel or gas control problems? _____

Describe any activities that you cannot or do not do because of your problem?

_____

_____

_____