Patient Information Form

Colorado Pelvic Floor Consultants
Female Pelvic Medicine & Reconstructive Surgery

Please Fill Out the Information Below

This information will assist us in your treatment. If you have difficulty answering these questions, please speak with a member of our staff for help at the time of your visit.

Name:_____

Date of Birth: _____ Phone Number: _____

Referring Physician: _____Phone Number: _____

Office address: _____

Primary Care Physician: _____Phone Number: _____

Office address: _____

Allergies

Allergies to medications (please list medication with symptoms): _____

_____

Check if allergic to: ☐ BETADINE ☐ IODINE ☐ LATEX ☐ TAPE

Current Medications: (Please list all medications you are currently taking, including over the counter non-prescription ones like aspirin, antacids, or herbal medications. Attach additional page, if necessary.)

	MEDICATION	DOSAGE	TIMES/DAY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Pharmacy Name and Location: _____

Pharmacy Phone Number: _____

Reviewed with Patient: ☐ Yes ☐ No

Nurse's Signature: _____Date: _____

Obstetrical History

Date of Delivery	Type of Delivery	Weight	Duration of Labor	Tears/Complications
_____	Vaginal / C-Section	_____	_____	_____
_____	Vaginal / C-Section	_____	_____	_____
_____	Vaginal / C-Section	_____	_____	_____
_____	Vaginal / C-Section	_____	_____	_____
_____	Vaginal / C-Section	_____	_____	_____

Gynecologic History

Menstrual History: every _____ days, X _____ days. LMP _____

Irregular Bleeding: _____ Postmenopausal Bleeding _____

STD's (Gonorrhea/Chlamydia) _____ Abnormal Pap Smears _____

Sexually active: Yes / No If yes: Satisfactory Unsatisfactory Painful Would like to discuss

Have you had a hysterectomy? Yes / No If yes: why? _____

Genitourinary History

Please check in the box if you currently have or have a history of any of the following medical problems:

Medical Problem / Illness	I currently have this problem	I have a history of this problem	Age when you had this symptom or disease
Childhood history of bladder infection or bed-wetting			
Chronic Cystitis (bladder infection)			
Pyelonephritis (kidney infection)			
Blood in your Urine			
Kidney Disease or Kidney Stones			

Colorectal History

Please check in the box if you currently have or have a history of any of the following medical problems:

Medical Problem / Illness	I currently have this problem	I have a history of this problem	Age when you had this symptom or disease
Constipation (infrequent bowel movements)			
Defecation Trouble			
Irritable Bowel Syndrome			
Fecal Incontinence			
Hemorrhoids			
Colonoscopy (list date of last test)			

Medical History

Medical Problem / Illness	I currently have this problem	I have a history of this problem	Age when you had this symptom or disease
Heart Murmur			
Rheumatic Heart Disease			
Artificial Heart Valve			
Asthma			
Bronchitis			
Pneumonia			
Diabetes Mellitus			
Thyroid Disorder			
Sickle Cell Anemia			
Bleeding Disorders (heavy bleeding following cuts to the skin)			
PE or DVT (clots in the legs or lungs)			
Hyperlipidemia (high cholesterol and triglycerides)			
Hypertension (high blood pressure)			
Multiple Sclerosis			
SLE (Lupus)			
Arthritis (if yes, is it rheumatoid or osteoarthritis)			
Ulcer/GERD (reflux)			
Fibromyalgia			
Headaches			
Seizure Disorder			
Psychiatric Disorder / Depression			
Low Back Pain			
Cancer of the female organs (if yes, which one: breast, ovary, uterus, or cervix)			
Colon Cancer			
Cancer (other)			
Glaucoma (what type: narrow or open angle)			
History of a blood transfusion			
Other			

Surgical History

Please circle Yes / No as indicated if you currently have a history of any of the following surgical procedures (additional space provided for comments):

Appendectomy (Removal of appendix)	Yes	No
Breast Surgery	Yes	No
Cardiovascular/Heart Surgery	Yes	No
Cholecystectomy (Removal of gallbladder)	Yes	No
Bowel or Esophageal Surgery	Yes	No
Gastric Surgery (surgery of the stomach)	Yes	No
Gynecologic Surgery (ovary, uterus, tubes)	Yes	No

Surgical History

Please circle Yes / No as indicated if you currently have a history of any of the following surgical procedures (additional space provided for comments):

Hernia Repair (groin, belly button, abdomen)	Yes	No
Back Surgery	Yes	No
Lung Surgery	Yes	No
Neurologic Surgery (brain or spinal cord)	Yes	No
Orthopedic Surgery (hips/knees/shoulders)	Yes	No
Otolaryngology Surgery (ear, nose or throat)	Yes	No
Splenectomy (removal of the spleen)	Yes	No
Urologic Surgery (kidneys, bladder)	Yes	No
Anorectal surgery (hemorrhoids, rectal prolapse)	Yes	No
Prior surgery for prolapse/urinary incontinence	Yes	No
Other Surgery	Yes	No

Social History

Martial Status:_____ Occupation: _____

Caffeine Use (Coffee/Tea/Soda)	Yes	No	Cups per day_____
Cigar / Pipe Smoking	Yes	No	Additional Information _____
Cigarette Smoking	Yes	No	_____ Packs per Day _____ Years Smoking
History of Smoking	Yes	No	_____ Year Quit _____Years Smoked
Alcohol Use	Yes	No	_____ Glasses per Day
Illegal Drug Use	Yes	No	If yes, please circle one: PAST PRESENT
Exercising Regularly	Yes	No	Additional Information _____

_____

Family History

	Alive and Well (circle one)	Deceased	Cause of Death (Age)
Mother	yes no		
Father	yes no		

Please check in the box if an immediate family member (not spouse) currently has or has a history of any of the following medical problems:

Medical Problem / Illness	List family member who has had this problem (for example: mother, father, sisters, brother, maternal grandmother - MGM, paternal grandfather - PGM, etc.)
Hypertension (high blood pressure)	
Diabetes Melltitus	
Sickle Cell Anemia	
Heart Disease	

Please check in the box if an immediate family member (not spouse) currently have or have a history of any of the following medical problems:

Medical Problem / Illness	List family member who has had this problem (for example: mother, father, sisters, brother, maternal grandmother - MGM, paternal grandfather - PGM, etc.)
Kidney Disease	
Cancer	
DVT or PE (clots in the legs or lungs)	
Bleeding Disorder (heavy bleeding following cuts to the skin)	

Review of Systems

Please let us know if you have experienced any of the following in the last 4 weeks (if yes, please describe):

1. Food or environmental allergies? Yes No _____
2. Chest pain? Yes No _____
3. Shortness of breath or persistent coughs? Yes No _____
4. Poor energy level, fevers or chills? Yes No _____
5. Problems with your ears, nose, or throat? Yes No _____
6. Unexpected weight gain or weight loss? Yes No _____
7. Heat or cold intolerance? Yes No _____
8. Problems with your eyes? Yes No _____
9. Blood in bowel movements, pencil thin movements, or black, tarry stools? Yes No _____
10. Unusual bruising or swelling of glands? Yes No _____
11. Skin rashes? Yes No _____
12. Muscle aches and pains? Yes No _____
13. Muscle weakness, seizures, or problems with your memory? Yes No _____
14. Depression or anxiety? Yes No _____

Current Concerns: _____

_____

_____

Reviewed with Patient: Yes No

Physician's Signature: _____

Date: _____

Comments: _____

_____

_____

Chief Complaint and Pertinent History (Physician to complete at your visit)

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Pelvic Floor Impact Questionnaire Short Form 7

Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question place an X in the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions over the last 3 months. Please make sure you mark an answer in all 3 columns for each question.

How do symptoms or conditions relate to the following usually affect your :	Bladder or Urine	Bowel or Rectum	Vagina or Pelvis
Ability to do household chores (cooking housecleaning, laundry)?	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Ability to do physical activities such as walking, swimming, or other exercise?	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Entertainment activities such as going to a movie or concert?	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit
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	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Participating in social activities outside your home?	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Emotional health (nervousness, depression, etc.)?	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Feeling frustrated?	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit	☐ Not At All ☐ Somewhat ☐ Moderately ☐ Quite a Bit

Scoring the PFIQ-7
All of the items use the following response scale:
None at All = 0, Somewhat = 1, Moderately = 2, Quite a Bit = 3

Scales:
Urinary impact questionnaire (UIQ-7): 7 items under column heading "Bladder or urine." Colorectal-anal impact questionnaire (CRAIQ-7): 7 items under column heading "Bowel or rectum."

Pelvic organ prolapse impact questionnaire (POPIQ-7): 7 items under column heading "Pelvis or vagina."

Scale score: obtain the mean value for all of the answered items within the corresponding scale (possible values Oto 3) and then multiply by (100/3) to obtain the scale score (range Oto 100). Missing items are dealt with by using the mean from answered items only.

PFIQ-7 Summary Score: Add the scores from the 3 scales together to obtain the summary score (Oto 300).

Barber MD, Kuchibhatla M, Pieper CF, Bump RC. Psychometric Evaluation Of 2 Comprehensive Condition -Specific Quality of Life Instruments for Women with Pelvic Disorders. American Journal of Obstetric and Gynecology Volume 185; November 6, 2001

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Pelvic Floor Distress Inventory Short Form 20

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)	
Usually experience pressure in the lower abdomen?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Usually experience heaviness or dullness in the pelvic area?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Usually have a bulge or something falling out that you can see or feel in your vaginal area?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Usually experience a feeling of incomplete bladder emptying?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit

Colorectal-anal distress inventory 8 (CRADI-8)	
Feel you need to strain too hard to have a bowel movement?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Feel you have not completely emptied your bowels at the end of a bowel movement?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Usually lose stool beyond your control if your stool is well formed?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Usually lose stool beyond your control if your stool is loose?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Usually lose gas from the rectum beyond your control?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Usually have pain when you pass your stool?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit

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Pelvic Floor Distress Inventory Short Form 20

Urinary Distress Inventory 6 (UDI-6)	
Usually experience frequent urination?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Usually experience urine leakage related to coughing, sneezing, or laughing?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Usually experience small amounts of urine leakage (that is, drops)?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Usually experience difficulty emptying your bladder?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit
Usually experience pain or discomfort in the lower abdomen or genital region?	☐ No ☐ Yes ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a Bit

PFDI-20 Summary Score: add the scores from the 3 scales together to obtain the summary score (range Oto 300). Scoring of PFDI-20 = (POPDI-6 + CRAID-8 + UDI-6).

Scale scores: obtain the mean value of the answered items within the corresponding scale (possible value Oto 4) and then multiply by 25 to obtain the scale score (range Oto 100). Missing items are dealt with by using the mean from answered items only.

No = 0, Not at all = 1, Somewhat = 2, Moderately = 3, Quite a bit = 4

https://app.webpt.com/printOMT.php?test=T508&random=56465639

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