Urogynecology of Oklahoma
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Patient Name: ______________________ D.O.B: ______________
Referring Physician: ______________________ Primary Physician: ______________________
Pharmacy: ____

Please describe the nature of the problem which brought you to our clinic: ______________________
____
____

Have you seen any other physicians for this problem: ☐ YES ☐ NO
If yes, please list the physician(s) and any evaluation or therapy they provided: ______________________
____
____

When did this problem start: ______________________
What have you tried for relief: ______________________
What makes the problem better: ______________________
Does anything worsen the problem: ______________________
How severe is the problem now: ☐ Mild ☐ Moderate ☐ Severe

☐ **NO KNOWN DRUG ALLERGIES**

ALLERGIES: Medication: ______________ Reaction: ______________
Medication: ______________ Reaction: ______________

CURRENT MEDICATIONS

Medication:	Dose:	Frequency:	Prescribed by:

Please attach sheet of additional medications and/or allergies if needed

GYNECOLOGY HISTORY

Are you sexually active: ☐ YES ☐ NO Is sex painful: ☐YES ☐ NO
History of sexually transmitted disease: ☐ YES ☐ NO if yes: please explain: ______________
History of herpes: ☐ YES ☐ NO ☐ Genital ☐ Oral ☐ Both Last outbreak: ______________
Hepatitis C: ☐ YES ☐ NO Date of diagnosis: __________ Treatment: ______________
HIV: ☐ YES ☐ NO Date of diagnosis: __________ Treatment: ______________

PREVENTATIVE HISTORY

Date of last pap: ______________ Normal results: ☐ YES ☐ NO Any follow up: __________________

Previous abnormal pap: ☐ YES ☐ NO If yes, follow up/treatment: ________________________________

Date of mammogram: _________ Normal results: ☐ YES ☐ NO Any follow up: ___________________

Previous abnormal mammo: ☐ YES ☐ NO If yes, follow up/treatment: _____________________________

Date of colonoscopy: __________ Normal results: ☐ YES ☐ NO Any follow up: ___________________

Previous abnormal colonoscopy: ☐ YES ☐ NO If yes, follow up/treatment: _________________________

PREGNANCY HISTORY

Total pregnancies: _____ Miscarriages: _____ Abortions: _____ Living children: _____

Lacerations: ☐ YES ☐ NO Tears into the rectum: ☐ YES ☐ NO

FAMILY HISTORY

Has any of your **immediate biological family members** had the following:

	Relationship to you:
Breast cancer	
Heart disease	
Colon cancer	
Ovarian cancer	
Prolapse (including cystocele/rectocele)	
Urinary incontinence	
Blood clotting disorder (DVT/PE)	
Other disease:	

SURGICAL HISTORY

Surgery	**Date of surgery/Reason**	**Surgery**	**Date of surgery/reason**
Bowel Surgery		Hysterectomy	
Urethral bulking (collagen or other material)		Ovaries removed: right, left or both	
Sling for incontinence		Prolapse surgery	
Bladder botox		Other abdominal surgery:	

YOUR PERSONAL MEDICAL HISTORY

Check if **YOU** have had

□ Heart Attack □ Stroke/TIA

□ Asthma/COPD □ Breast cancer □ Bladder Cancer □ Pelvic Radiation

□ Uterine Cancer □ Liver disease □ Thyroid Disease □ Dementia/Alzheimer's

□ Ovarian Cancer □ Endometrosis □ Kidney Disease □ High Blood Pressure

□ Blood Clots (DVT/PE) □ Bleeding/Clotting disorder □ Lupus/Autoimmune Disorder

□ Other Cancer: ______________________________

Other Medical Problems	Date of Diagnosis	Treating Provider
1		
2		

Do you have diabetes: □ YES □ NO Date of diagnosis: ______________

What was your last Hgb A1C: ______________________ Date: ______________________

OTHER

How many times in a day do your urinate: ______________________________

How many times do you urinate at night: ______________________________

Have you ever tried over active bladder medication: □ YES □ NO

If yes, which medications have you tried: ______________________________

How frequent are your bowel movements: ______________________________

Do you have difficulty with your bowel movements: □ YES □ NO

Do you take anything to help with constipation: ______________________ ______________

How much water do you drink per day: ______________________________

What is your caffeine intake per day: ______________________________

SOCIAL HISTORY

DO YOU:	if yes, please describe:
Drink alcohol	
Use Marijana	
Use street drugs	
Smoke Cigarettes	
Use E-cigarettes (vape)	