Northwestern Medicine
Women's Integrated
Pelvic Health Program

Tel: (312) 694-7337
Fax: (312) 695-0156

1.0: Basic Information

Name: _____ **Preferred Language:** ☐ English ☐ Spanish ☐ Other: _____

Date of Birth: ____/____/____

Age: _____

Home Address: _____

_____

Email address: _____

Preferred Contact Number: ( ) -

Emergency Contact Name: _____

Emergency Contact Number: ( ) -

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian/Asian American
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other:_____

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Employment:
- ☐ Employed part-time
- ☐ Employed full-time
- ☐ Unemployed
- ☐ Retired

Marital Status:
- ☐ Married/civil union
- ☐ Living with a partner
- ☐ Separated or divorced
- ☐ Widowed
- ☐ Single, never married

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2.0: Today's Visit		
Referring Provider:	Name:	
	Address:	
	Phone Number:	**( ) -**
	Fax Number:	**( ) -**
Primary Care Physician:	Name:	
	Address:	
	Phone Number:	**( ) -**
	Fax Number:	**( ) -**
General Ob/Gyn:	Name:	
	Address:	
	Phone number:	**( ) -**
	Fax Number:	**( ) -**

Please describe the nature of your <u>current</u> pelvic floor medical problem and include any treatments you have tried for this problem in the past.

Women have different goals for their pelvic care. Please list your **personal goals** for treatment of your pelvic problems in order of importance.

Please also rate the level of importance of achieving this treatment goal on a scale from **0 (not important to me) to 10 (very important to me).**

Ranking:	**My personal goals** for treatment are:	Rating of level of achieving treatment goal
1.		
2.		
3.		
4.		
5.		

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3.0: Chief Complaint, Allergies & Medications

What is the main reason for your visit today? _____

Please list any drug allergies: _____

Pharmacy:

Name: _____

Address: _____

Phone Number: **( ) -** _____

Please list any medications you are currently taking:		
Medication Name	**Start Date**	**Prescribing Physician**

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History Form

You may receive a phone call from a staff member in our practice to discuss this information before your appointment.

4.0: Medical History

Please check any/all of the below medical problems that you have or have had in the past.

Cardiovascular	Gastrointestinal:
☐ Coronary artery disease (I25.1) ☐ Previous myocardial infarction (heart attack) ☐ Congestive Heart Failure (I50.42) ☐ Heart murmur (R01.1) ☐ High blood pressure (I10) ☐ Peripheral vascular disease (I73.9) ☐ Atrial fibrillation (I48.91) ☐ High cholesterol (E78.5) ☐ Other:_____	☐ Irritable Bowel Syndrome (IBS) (K58.0) ☐ Stomach Ulcer (K25.9) ☐ Duodenal Ulcer (K26.0) ☐ Chron's Disease (K50.1) ☐ Ulcerative Colitis (K51.00) ☐ Esophageal reflux (K21.9) ☐ Liver disease Hepatitis ☐ A ☐ B ☐ C ☐ Cirrhosis (K74.6) ☐ Other: _____
Neurological / Psychological:	**Respiratory:**
☐ Parkinson's Disease (G20) ☐ Multiple Sclerosis (G35) ☐ Stroke or TIA (I69) ☐ Seizure disorder (G40) ☐ Depression (F32.9) ☐ Anxiety (F41.9) ☐ Insomnia (F51.01) ☐ Other: _____	☐ COPD / Emphysema (J44.9) ☐ Pneumonia (J18.1) ☐ Asthma (J45.20) ☐ Tuberculosis (A15.0) ☐ Sleep apnea (G47.33) ☐ Other: _____
Endocrine:	**Musculoskeletal:**
☐ Hypothyroidism (E03.9) ☐ Hyperthyroidism (E05.90) ☐ Grave's Disease (E05.00) ☐ Type 1 Diabetes (E10.9) ☐ Type 2 Diabetes (E11.9) ☐ Other: _____	☐ Arthritis ☐ Osteoarthritis (M19.91) ☐ Rheumatoid arthritis (M05.9) ☐ Osteopenia (M85.80) ☐ Osteoporosis (M81.0) ☐ Other: _____
☐ **Cancers, other medical problem (please specify):**	

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5.0: Surgical History

Have you had a hysterectomy?

- ☐ No
- ☐ Yes, an abdominal hysterectomy
- ☐ Yes, a vaginal hysterectomy
- ☐ Yes, a laparoscopic/robotic hysterectomy

Have you had your ovaries removed?

- ☐ No
- ☐ Yes

Please list any other surgeries you have had below:	Date	Surgeon:

6.0: Family History

Have any of your first-degree relatives (parents, siblings, children) had any of the medical problems below?

Problem:	Family member:	
Breast cancer	☐ Mother ☐ Father	☐ Sibling ☐ Child
Uterine cancer	☐ Mother ☐ Father	☐ Sibling ☐ Child
Ovarian cancer	☐ Mother ☐ Father	☐ Sibling ☐ Child
Colon cancer	☐ Mother ☐ Father	☐ Sibling ☐ Child
Bleeding or clotting problems	☐ Mother ☐ Father	☐ Sibling ☐ Child
Leakage of urine	☐ Mother ☐ Father	☐ Sibling ☐ Child
Pelvic organ prolapse	☐ Mother ☐ Father	☐ Sibling ☐ Child

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7.0: Social History

	Currently	Formerly	Never
Do you or have you used tobacco? **Check all that apply**: Cigarettes ☐ Cigars ☐ Smokeless Tobacco ☐	☐	☐	☐
If you are a smoker, how many packs per day do you smoke? _____			
Do you drink alcohol?	☐	☐	☐
If you drink alcohol, how many drinks do you have per week? _____			
Have you used any recreational drugs (e.g. marijuana, narcotics, etc)?	☐	☐	☐
If you use recreational drugs, how many times do you use them per week? _____			
Do you exercise?	☐	☐	☐
If you currently exercise, what type of exercise do you do and how often? _____			

Are you sexually active?	**Yes** ☐	**No** ☐
If you are currently sexually active, please indicate your partner's gender. **Male** ☐ **Female** ☐ **Both** ☐		
Are you satisfied with your sexual function?	**Yes** ☐	**No** ☐

If you are not satisfied with your sexual function, which problem(s) do you have?

☐ Decreased interest ☐ Pain with sex ☐ Decreased vaginal lubrication

☐ Problems with orgasm ☐ Decreased genital sensation ☐ Other: _____

8.0: Obstetrical and Gynecological History

	0	1	2	3	4	5	6	7	8	9	10
How many times have you been pregnant?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How many children have you delivered?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How much did your largest infant weigh at birth? _____ N/A ☐											
How many of your deliveries were forceps assisted?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How many were vacuum assisted?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How many were cesarean sections?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

When was your last…	Date	Results	
		Normal	Abnormal
PAP smear?		☐	☐
Mammogram?		☐	☐
Colonoscopy?		☐	☐
Menstrual Period?			

Are you post-menopausal?

☐ Yes
☐ No

If you are post-menopausal, have you had any bleeding since menopause?

☐ Yes
☐ No

Do you or have you taken hormone pills (birth control, hormone replacement)?

☐ Yes (please specify): _____
☐ No

Have you ever had an abnormal PAP smear?

☐ Yes
☐ No

If you have had an abnormal pap smear, did you have any of the following procedures performed?

☐ LEEP
☐ Cone biopsy
☐ Cryoablation ("freezing")
☐ Laser ablation
☐ Colposcopy
☐ Not applicable

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9.0: Review of Systems

Please check any or all items that you are currently experiencing.

How do you feel today?	Constitutional
☐ Well ☐ Acutely unwell ☐ Chronically unwell	☐ Fever ☐ Tremors ☐ Night sweats ☐ Fatigue ☐ Weight loss ☐ Weight gain ☐ Pain ☐ No Symptoms
Eyes, Ears, Nose & Throat	**Skin/Breast**
☐ Glaucoma ☐ Hearing Loss ☐ Nose Bleeds ☐ Sinus Problems ☐ Bleeding gums ☐ No Symptoms	☐ Itching ☐ Rash ☐ Dryness ☐ Flaky ☐ Breast pain ☐ Breast mass/lump ☐ Nipple discharge ☐ No Symptoms
Gastrointestinal	**Cardiac**
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Soreness of mouth ☐ Difficulty swallowing ☐ Poor appetite ☐ Constipation ☐ Abdominal Pain ☐ Blood in stool ☐ No Symptoms	☐ Chest pain ☐ Palpitation ☐ Shortness of breath ☐ Feet swelling ☐ No Symptoms
Pulmonary/Respiratory	**Genitourinary**
☐ Coughing ☐ Coughing blood ☐ Wheezing/asthma ☐ No Symptoms	☐ Painful or difficult urination/dysuria ☐ Increased frequency of urination ☐ Urinary incontinence ☐ No Symptoms
Gynecological	**Neurological**
☐ Vaginal dryness ☐ Vaginal soreness ☐ No Symptoms	☐ Headache ☐ Double vision/Diplopia ☐ Seizures ☐ Lightheaded/dizzy ☐ Tremors ☐ Numbness/tingling ☐ No Symptoms
Psychological	**Musculoskeletal**
☐ Anxiety/Depression ☐ Insomnia ☐ Memory loss/confusion ☐ No Symptoms	☐ Fatigue/weakness ☐ Muscle soreness/pain ☐ Joint pain ☐ Back pain ☐ No Symptoms

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10.0: Pelvic Floor Questionnaire (PFDI)

Instructions: Please answer the following question by circling the appropriate number. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms over the **last three months**. Thank you for your help.

	NO	YES			
		If yes, how much does it bother you?			
		Not at all	Somewhat	Moderately	Greatly
1. Do you usually experience pressure in the lower abdomen?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
2. Do you usually experience *heaviness or dullness* in the pelvic area?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
5. Do you usually experience a feeling of incomplete bladder emptying?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
7. Do you feel you need to strain too hard to have a bowel movement?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
8. Do you feel that you have not completely emptied your bowels at the end of a bowel movement?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
9. Do you usually lose stool beyond your control if your stool is well formed?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
11. Do you usually lose gas from the rectum beyond your control?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

	NO	YES			
		If yes, how much does it bother you?			
		Not at all	**Somewhat**	**Moderately**	**Greatly**
12. Do you usually have pain when you pass your stool?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
15. Do you usually experience frequent urination?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
16. Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
17. Do you usually experience urine leakage related to coughing, sneezing, or laughing?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
18. Do you usually experience small amounts of urine leakage? (this is, drops)?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
19. Do you usually experience difficulty emptying your bladder?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
20. Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐