



**Ginger N. Cathey, MD**  
**Urogynecology**  
**7900 Fannin, Suite 4000**  
**Houston, TX 77054**

Name: \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Age: \_\_\_\_\_

Reason for visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide name, address and phone number for the following physicians or healthcare providers:

Who referred you to us? \_\_\_\_\_  
\_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_  
\_\_\_\_\_

Who is your regular gynecologist? \_\_\_\_\_  
\_\_\_\_\_

Do you see any specialists?

Name, address, phone number

Gastroenterologist \_\_\_\_\_

Cardiologist \_\_\_\_\_

Urologist \_\_\_\_\_

Colorectal Surgeon \_\_\_\_\_

Other \_\_\_\_\_

## History

### URINARY INCONTINENCE

- Yes**    **No**  
 Y     N    Do you have accidental loss of urine?  
\_\_\_\_\_ How many months or years have you had leakage of urine?
- Y     N    Do you wear pads to absorb lost urine?  
\_\_\_\_\_ If yes, what size pad do you wear?  
\_\_\_\_\_ How many pads do you wear in a day?  
\_\_\_\_\_ How many trips to the bathroom do you make during the day from the time you wake up in the morning until the time you go to sleep at night?
- Y     N    Does an uncomfortably strong need to pass urine wake you up?  
\_\_\_\_\_ How many times are you awakened during the night after going to sleep by an urge to urinate?
- Y     N    Does the sound, sight or feel of running water cause you to lose urine?
- Y     N    Do you lose urine during the act of intercourse at penetration?
- Y     N    Do you lose urine during orgasm?
- Y     N    I lose urine during coughing, sneezing, running or heavy lifting
- Y     N    I lose urine with changes in posture, standing or walking
- Y     N    I lose urine continuously such that I am constantly wet
- Y     N    Have you seen a physician for complaints of urine loss?
- Y     N    Have you taken medicine to prevent urine loss?  
If yes, name the medication \_\_\_\_\_
- Y     N    Have you had surgery to prevent urine loss?  
If yes, was it done through the vagina?  
Was it done through the abdomen?
- Y     N    Do you notice any dribbling or urine when you stand after passing your urine?
- Y     N    Do you usually have difficulty starting your urine stream?
- Y     N    Have you ever required catheterization for the inability to pass your urine?
- Y     N    Do you always feel that your bladder is empty after passing urine?

- Y     N    Have you seen any blood in your urine?
- Y     N    Do you have any burning with urination?
- Y     N    Have you had 3 or more urinary tract infections in the last year?

**GENITOURINARY PROLAPSE**

- Y     N    Do you have a bulge or mass in your vagina:  
 \_\_\_\_\_ How many months or years have you had this bulge or mass?
- Y     N    Have you seen a doctor for this bulge or mass in your vagina?
- Y     N    Have you worn a pessary for this problem?  
 \_\_\_\_\_ If yes, how many months or years have you worn this pessary?
- Y     N    Have you had surgery in the past for a bulge or mass in the vagina?

**FECAL INCONTINENCE**

- Y     N    Do you have accidental loss of solid stool?
- Y     N    Do you have accidental loss of liquid stool?
- Y     N    Do you have accidental loss of gas?  
 \_\_\_yr\_\_\_mo How many months or years have you had accidental loss of stool or gas?
- Y     N    Have you seen a doctor for this problem?
- Y     N    Did the problem with accidental loss of stool begin after childbirth?
- Y     N    Do you wear protective pads for this problem?  
 \_\_\_\_\_ If yes, what size pad do you wear?  
 \_\_\_\_\_ How many pads do you wear each day?
- Y     N    Are you able to sense the need to have a bowel movement?
- Y     N    Are you able to tell the difference between solid stool/liquid stool/gas?
- Y     N    Do you have a frequent desire to have a bowel movement?
- Y     N    Have you had surgery for this problem?
- Y     N    Has there been a change in your bowel habits recently?

- Have you noticed any bright red bleeding with your bowel movements?
- Have you noticed black or "tarry" stools?
- Are your bowel movements painful?

**CONSTIPATION**

- Do you have constipation?
- Do you excessively strain to pass stool more than 25% of the time?
- Do you have at least three bowel movements each week?
- \_\_\_\_\_ How many bowel movements do you have each week?
- Do you pass hard, small stool?
- \_\_yr\_\_mo How many months or years have you had constipation?
- Have you seen a doctor for this problem?
- Do you use any medication or over the counter products for this?  
If yes, what have you used? \_\_\_\_\_
- Have you had surgery for this problem?
- Have you ever placed your hand or fingers in your vagina or between your vagina and rectum to help bring about a bowel movement?
- Do you have a feeling of incomplete emptying after bowel movements?
- Have you had a colonoscopy? Date: \_\_\_\_\_

**PAST GYN HISTORY**

Last pap test (month & year): \_\_\_\_\_

Have you ever had an abnormal pap smear? Yes No If yes, what year? \_\_\_\_\_

Last mammogram (month & year): \_\_\_\_\_

Have you ever had an abnormal mammogram? Yes No If yes, what year? \_\_\_\_\_

Have you gone through menopause?  
If yes, at what age did you go through menopause? \_\_\_\_\_  
If no, are your periods regular? \_\_\_\_\_

Have you had any vaginal bleeding or spotting since menopause?

Have you had a hysterectomy?

If yes, was it done through the vagina or abdomen or laparoscopically ? (Please circle)

- Do you have your ovaries?  
If yes, both or only one (Please circle)
- Have you had surgery for leakage of urine?
- Have you had surgery for prolapse, "bulges" or "fallen pelvic organs"?

**PAST OBSTETRICAL HISTORY**

Number of Pregnancies \_\_\_\_\_  
 Number of Vaginal Births \_\_\_\_\_  
 Number of C-Sections \_\_\_\_\_  
 Weight of Largest Baby \_\_\_\_\_

**SEXUAL HISTORY**

- Sexually Active? If no, why? Please circle
- |                      |                                      |
|----------------------|--------------------------------------|
| 1. No partner        | 4. Painful intercourse               |
| 2. Partner factor    | 5. Because of bulge or leak symptoms |
| 3. Loss of sex drive | 6. Other                             |
- Partner: Male Female Both (Please circle)

- Contraception? If yes, please circle
- |                            |                   |
|----------------------------|-------------------|
| 1. Tubal ligation          | 5. Depo-provera   |
| 2. Birth control pills     | 6. Barrier        |
| 3. Intrauterine device IUD | 7. Postmenopausal |
| 4. Diaphragm               | 8. Other          |

- Pain with intercourse: If yes, please circle one or both
- Near vaginal opening
  - Inside abdomen/pelvic area

**SURGERIES/HOSPITALIZATIONS**

Date(s) and reason(s) for surgery/hospitalization:

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- Any problems with anesthesia during any surgeries?

Explain? \_\_\_\_\_

**INJURIES/ILLNESSES**

Date(s) and description(s) of injuries and/or illnesses:

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**PAST MEDICAL HISTORY**

Have you ever been diagnosed with any of the following?

<input type="checkbox"/> Y	<input type="checkbox"/> N	Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Skin problems
<input type="checkbox"/> Y	<input type="checkbox"/> N	Pneumonia	<input type="checkbox"/> Y	<input type="checkbox"/> N	Liver problems
<input type="checkbox"/> Y	<input type="checkbox"/> N	Lung disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Thyroid disease
<input type="checkbox"/> Y	<input type="checkbox"/> N	Kidney problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Gastric Reflux
<input type="checkbox"/> Y	<input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Psychiatric illness
<input type="checkbox"/> Y	<input type="checkbox"/> N	Venereal disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Cancer
<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart trouble/murmur	<input type="checkbox"/> Y	<input type="checkbox"/> N	Ulcers
<input type="checkbox"/> Y	<input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Depression/anxiety
<input type="checkbox"/> Y	<input type="checkbox"/> N	High blood pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Seizures /epilepsy
<input type="checkbox"/> Y	<input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N	Bowel trouble
<input type="checkbox"/> Y	<input type="checkbox"/> N	Migraine Headaches	<input type="checkbox"/> Y	<input type="checkbox"/> N	Glaucoma
<input type="checkbox"/> Y	<input type="checkbox"/> N	Blood disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Arthritis/joint pain
<input type="checkbox"/> Y	<input type="checkbox"/> N	Transfusions	<input type="checkbox"/> Y	<input type="checkbox"/> N	Fracture
<input type="checkbox"/> Y	<input type="checkbox"/> N	Drug or alcohol abuse	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hepatitis / AIDS
<input type="checkbox"/> Y	<input type="checkbox"/> N	Muscle or bone problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	High Cholesterol
<input type="checkbox"/> Y	<input type="checkbox"/> N	Chronic pain	Other	_____	

**FAMILY HISTORY**

Has a **blood-related** family member had any of these illnesses:

Yes	No	Don't Know		Relationship
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prolapse	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary incontinence	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fecal incontinence	_____

**PERSONAL AND SOCIAL HISTORY**

Who lives in your home with you? \_\_\_\_\_

Current marital status: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_

**Ethnic Background:** Caucasian \_\_\_\_\_ African-American \_\_\_\_\_  
 Hispanic \_\_\_\_\_ Asian \_\_\_\_\_ Other \_\_\_\_\_

Are you employed? If so, occupation: \_\_\_\_\_

Does your job or a hobby require heavy physical work?

**Education**

Level of Education: \_\_\_\_\_ Up to 12<sup>th</sup> Grade \_\_\_\_\_ Beyond 12<sup>th</sup> Grade

**Personal Habits**

Smoking Packs per day: \_\_\_\_\_ Years of use: \_\_\_\_\_

Alcohol Drinks per day: \_\_\_\_\_ Drinks per week: \_\_\_\_\_

Recreational Drug Use What type? \_\_\_\_\_ How often? \_\_\_\_\_



## **REVIEW OF SYSTEMS**

Please check appropriate box if any of the following apply to you and these are problems that have not been evaluated prior. If checked, please explain.

### **Notes**

<b>1. Constitutional</b>		
Weight loss	<input type="checkbox"/>	_____
Weight gain	<input type="checkbox"/>	_____
Fever/ Chills	<input type="checkbox"/>	_____
Fatigue	<input type="checkbox"/>	_____
<b>2. Eyes</b>		
Double vision	<input type="checkbox"/>	_____
Spots before eyes	<input type="checkbox"/>	_____
Vision changes	<input type="checkbox"/>	_____
<b>3. ENT/Mouth</b>		
Ear aches	<input type="checkbox"/>	_____
Sinus problems	<input type="checkbox"/>	_____
Sore throat	<input type="checkbox"/>	_____
Mouth sores	<input type="checkbox"/>	_____
Dental problems	<input type="checkbox"/>	_____
<b>4. Cardiovascular</b>		
Chest pain	<input type="checkbox"/>	_____
Difficult breathing on exertion	<input type="checkbox"/>	_____
Swelling of legs	<input type="checkbox"/>	_____
Palpitations of heart	<input type="checkbox"/>	_____
<b>5. Respiratory</b>		
Wheezing	<input type="checkbox"/>	_____
Spitting up blood	<input type="checkbox"/>	_____
Shortness of breath	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	_____
<b>6. Gastrointestinal</b>		
Abdominal Pain	<input type="checkbox"/>	_____
Blood in stool	<input type="checkbox"/>	_____
Nausea/vomiting	<input type="checkbox"/>	_____
<b>7. Musculoskeletal</b>		
Muscle weakness	<input type="checkbox"/>	_____
Joint pain	<input type="checkbox"/>	_____
Back pain	<input type="checkbox"/>	_____

**REVIEW OF SYSTEMS Continued**

**Notes**

<b>8. Skin/Breast</b>		
Pain in breast	<input type="checkbox"/>	_____
Discharge	<input type="checkbox"/>	_____
Masses	<input type="checkbox"/>	_____
Rash	<input type="checkbox"/>	_____
Ulcers	<input type="checkbox"/>	_____
<b>9. Neurological</b>		
Dizzy spells	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	_____
Numbness/ tingling	<input type="checkbox"/>	_____
Trouble walking	<input type="checkbox"/>	_____
<b>10. Psychiatric</b>		
Depression	<input type="checkbox"/>	_____
Frequent Crying	<input type="checkbox"/>	_____
Thoughts of Suicide	<input type="checkbox"/>	_____
<b>11. Endocrine</b>		
Dry skin	<input type="checkbox"/>	_____
Abnormal thirst	<input type="checkbox"/>	_____
Hot flashes	<input type="checkbox"/>	_____
<b>12. Hematologic/lymphatic</b>		
Frequent bruises	<input type="checkbox"/>	_____
Cuts that don't stop bleeding	<input type="checkbox"/>	_____
Enlarged lymph nodes	<input type="checkbox"/>	_____
<b>13. Allergic/immunologic</b>		
Allergies	<input type="checkbox"/>	_____
Drug/ Latex allergies	<input type="checkbox"/>	_____

**Please list any other concerns you may have regarding your medical history and care.**

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Completed by: Patient  Family Member  Office Nurse  Physician

Signature of patient: \_\_\_\_\_

Date reviewed by physician with patient: \_\_\_\_\_

Physician signature: \_\_\_\_\_

# WOMEN'S PELVIC HEALTH & CONTINENCE CENTER

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## VOIDING DIARY (UROLOG)

THIS CHART IS A RECORD OF YOUR VOIDING (URINATING) AND LEAKAGE (INCONTINENCE) OF URINE. PLEASE READ THE DIRECTIONS CAREFULLY AND COMPLETE THIS SHEET PRIOR TO YOUR FIRST APPOINTMENT. CHOOSE A 24 HOUR PERIOD TO KEEP THIS RECORD WHEN YOU CAN MEASURE EVERY VOID. START THE CHART WITH THE FIRST VOID WHEN YOU GET UP IN THE MORNING.

WE REALIZE THIS MAY BE AN INCONVENIENCE, BUT THE INFORMATION IT PROVIDES IS VERY IMPORTANT IN ASSESSING YOUR BLADDER PROBLEM. WE MAY HAVE TO RESCHEDULE YOUR APPOINTMENT IF THIS DIARY IS NOT AVAILABLE AT YOUR FIRST APPOINTMENT.

YOU MAY MEASURE AMOUNTS IN OUNCES OR IN CC'S-BUT PLEASE INDICATE WHICH YOU ARE USING.

NOTE: 1 CUP = 8 OUNCES = 240 CC'S

1. TIME Record time of every time you void, leak or drink.
2. AMOUNT VOIDED Measure and write down amount of urine voided.
3. ACTIVITY Write down what you were doing when you leaked or lost control of your bladder. Examples are: getting out of a chair, bending over, vacuuming, gardening, doing dishes, taking shower, etc. If you were NOT doing anything active, write down whether you were standing, sitting or lying down.
4. AMOUNT LEAKED Estimate the amount you leaked according to this scale:  
  
1 = damp, few drops only.  
2 = wet underwear or pad.  
3= soaked pad or clothing or bladder emptied completely.
5. URGE PRESENT If you had an urge to void before or at the time of the leakage write YES. If there was NO urge or you didn't realize you were voiding write NO
6. AMOUNT AND TYPE OF FLUID Measure and write down the amount and type of all liquids you drink.













