Advanced Pelvic Surgery, LLC

PATIENT HISTORY FORM

Visit Date_____

Name _____ Date of Birth _____ Age_____

Referring Physician _____ Primary Physician _____

History of Present Illness (Please answer the following)

Chief complaint: What is the main reason for your visit? (Please describe your problem in detail) _____

_____

_____

How long have you had the problem? _____

What makes it worse or better? _____

Please list all bladder, bowel, or Gyn surgeries: _____

_____

Do you have urine loss: with activity or coughing? _____ with the urge to urinate? _____

How many times per day? _____ Do you need pads? _____ How many per day? _____

Do you have problems with: starting your urine stream? _____poor flow? _____

emptying? _____ dribbling? _____ wetting the bed? ____

How long can you go between urinations during the daytime? _____ nighttime? _____

When was your last urinary tract infection? _____ Have you ever had kidney stones or blood in your urine? _____ What was done to treat it? _____

How often do you move your bowels? _____ Do you have trouble moving your bowels? _____ If yes, what is the trouble? _____ Do you have problems controlling gas? _____ stool? _____

Do you feel as if your bladder, uterus or rectum has fallen? _____ Is there tissue outside the vaginal opening? _____

How many vaginal deliveries did you have? _____ C-Sections? _____ Living children? _____

Did you have any difficulties with delivery? _____

When did your last menstrual period begin? _____ What form of birth control do you use? _____ When was your last Pap smear? _____ Was it normal? _____

When was your last Mammogram? _____ Was it normal? _____

Physician use only

Past Medical & Surgical History (Please answer all questions)

List all current medications, vitamins, and supplements **& *dosages***:

_____

_____

List all drug allergies and the problems caused: _____

List any medical problems you have: _____

_____

List any surgeries you have had and the date of surgery: _____

_____

List serious medical problems in your immediate family: _____

Social History

How much do you smoke? _____ How much do you drink? _____ Marital Status? _____

What is your occupation? _____ Are you sexually active? _____

Physician use only