Westwood Women's Health

Urogynecology Questionnaire

Name _____ Age _____

Date _____

What is the concern that led you to this evaluation?

_____

_____

_____

_____

Have you had any surgery before?

Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

How many times have you given birth?

Vaginal: _____ Were forceps or vacuum ever used? Yes _____ No _____

Cesarean: _____

How much did your largest baby weigh?

Please list your current medications

Prescription	Non-Prescription
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Do you ever lose urine accidentally when you laugh, cough, sneeze or exercise?

Yes ___ No ___ Sometimes ___

If yes, for how long has this been a problem? _____

Is it getting worse? Yes ___ No ___

Do you ever feel urinary urgency, like you need to urinate right away? Yes ___ No ___ Sometimes ___

If yes, do you ever lose urine on the way to the bathroom without being able to control it?

Yes ___ No ___ Sometimes ___

Is it getting worse? Yes ___ No ___

Do you wake up in the middle of the night to urinate? Yes ___ No ___ Sometimes ___

If yes, how many times per night? _____

Do you ever wet your bed? Yes ___ No ___

Do you have pain/burning when you urinate? Yes ___ No ___ Sometimes ___

Have you had frequent bladder infections? Yes ___ No ___

Have you had frequent kidney infections? Yes ___ No ___

Have you had kidney or bladder stones? Yes ___ No ___

Is your urine ever bloody? Yes ___ No ___

Do you ever have difficulty starting your urine stream? Yes ___ No ___ Sometimes ___

Do you feel like your urine stream is weak? Yes ___ No ___ Sometimes ___

When you urinate, is your urine stream intermittent? Yes ___ No ___ Sometimes ___

When you urinate, do you feel like you empty your bladder completely?

Yes ___ No ___ Sometimes ___

Do you every have to push up inside your vagina to urinate? Yes ___ No ___

Do you ever have dribbling of urine when you stand up after urinating? Yes ___ No ___ Sometimes ___

Have you ever seen a urologist? Yes ___ No ___

If yes, what was your diagnosis? _____

Have you ever had urethral dilatation? Yes ___ No ___ If yes, how many times? _____

Have you ever had cystoscopy (looking into your bladder with a scope)? Yes ___ No ___

Have you ever had urodynamic studies? Yes ___ No ___

Do you feel pressure or a bulge in your vagina? Yes ___ No ___ Sometimes ___

Do you wear a pad or panty liner to protect yourself from leakage? Yes ___ No ___ Sometimes ___

If yes, how many times a day do you change pads? _____

Do you have trouble with constipation? Yes ___ No ___ Sometimes ___

Do you have any trouble with fecal incontinence (involuntary loss of stool) or controlling gas?

Yes ___ No ___ Sometimes ___

When you need to have a bowel movement, do you get a strong sense of urgency?

Yes ___ No ___ Sometimes ___

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Do you feel like you empty your bowels completely when you have a bowel movement?

Yes ___ No ___ Sometimes ___

Do you ever have to push down in the back of your vagina to have a bowel movement?

Yes ___ No ___ Sometimes ___

Name_____ Date _____

Please answer each question by checking the best response between 0 (not at all) and 3 (greatly)

Has urinary leakage and/or prolapse affected your:	0 = not at all	1 = slightly	2 = moderately	3 = greatly	
1. Ability to do household chores (cooking, housecleaning, laundry)?					PA
2. Physical recreation such as walking, Swimming, or other exercise?					PA
3. Entertainment activities (movies, concerts, etc)?					T
4. Ability to Travel by car or bus more Than 30 minutes from home?					T
5. Participation in social activities outside your home?					SR
6. Emotional health (nervousness Depression, etc.)?					EH
7. Feeling frustrated					EH

Do you experience, and, if so, how much are you bothered by:	0 = not at all	1 = slightly	2 = moderately	3 = greatly	
1. Frequent urination?					I
2. Urine leakage related to the feeling of urgency?					I
3. Urine leakage related to physical Activity, coughing, or sneezing?					S
4. Small amounts of time leakage (drops)?					S
5. Difficulty emptying your bladder?					OD

6. Pain or discomfort in the lower Abdominal or genital area?					OD
7. A feeling of bulging or protrusion in the vaginal area?					OD
8. Bulging or protrusion you can see in The vaginal area?					OD