Weill Cornell Medicine | NewYork-Presbyterian

TANAKA J. DUNE, MD, FACOG
Urogynecology
Center For Female Pelvic Health

Name:_____ Date of Birth_____

Primary Care Physician:_____
Address:_____
City:_____State:_____Zip:_____
Phone Number: (___)_____
Fax Number: (___)_____

Referring Physician:_____
Address:_____
City:_____State:_____Zip:_____
Phone Number: (___)_____
Fax Number: (___)_____

Pharmacy Information
Name of Pharmacy_____
Address:_____
City:_____State:_____Zip:_____
Phone Number: (___)_____
Fax Number: (___)_____

525 E 68th Street, F9-West, New York, NY 10065 | T. 646.962.9600 | F. 646.962.0715 | tjd9004@med.cornell.edu

Name:_____ Date of Birth_____

What is the Primary Reason That Brings You in Today?

_____

Past Gynecologic History

Age at menopause_____ N/A____

Are you sexually active ○ Yes ○ No

Pain with intercourse ○ Yes ○ No

Contraception ○ Yes ○ No ○ N/A

Date of last Pap Smear: _____ Normal? Yes____ No____

Date of last Mammogram: _____ Normal? Yes____ No____

Date of last Colonoscopy: _____ Normal? Yes____ No____

Past obstetric History

Have you ever delivered? ○ Yes ○ No (number)____

Deliveries	Date	Vaginal/Cesarean	Weight	Forceps/Vacuum	Episiotomy/Laceration (Y/N)
1.					
2.					
3.					
4.					

Past Medical History

Medical Problems/Illnesses

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.

Past Surgical History

Date	Procedure
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Family History

Has anyone in your family had any of these diseases? If so, please give relationship

Breast Cancer_____ Ovarian Cancer_____

Uterine Cancer_____

Social History

Tobacco Use	○ Yes	○ No	Former	○ Yes	Current	○ Yes	
Alcohol/Drug Use	○ Yes	○ No					
Regular Exercise	○ Yes	○ No					

Medication List (leave blank if none)

Medication	Dose	Route (Oral / Injection / Vaginal)	How Often
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Medication Allergies (leave blank if none)

Medication	Reaction
1.	
2.	
3.	
4.	
5.	

REVIEW OF SYSTEMS

Do you have problems related to the following systems? Please mark the box ☐corresponding to No or Yes. Please *explain* any Yes answers in the space provided.

Constitutional Symptoms
- Fever ☐ No ☐ Yes
- Chills ☐ No ☐ Yes
- Headache ☐ No ☐ Yes
- Other _____

Eyes
- Blurred vision ☐ No ☐ Yes
- Double vision ☐ No ☐ Yes
- Pain ☐ No ☐ Yes
- Other _____

Allergic/Immunologic
- Hay fever ☐ No ☐ Yes
- Drug allergies ☐ No ☐ Yes
- Other _____

Neurological
- Tremors ☐ No ☐ Yes
- Dizzy spells ☐ No ☐ Yes
- Numbness/tingling ☐ No ☐ Yes
- Other _____

Endocrine
- Excessive thirst ☐ No ☐ Yes
- Diabetes ☐ No ☐ Yes
- Hypothyroid ☐ No ☐ Yes
- Other _____

Gastrointestinal
- Abdominal pain ☐ No ☐ Yes
- Nausea/vomiting ☐ No ☐ Yes
- Indigestion/heartburn ☐ No ☐ Yes
- Other _____

Cardiovascular
- Varicose veins ☐ No ☐ Yes
- Chest pain ☐ No ☐ Yes
- High blood pressure ☐ No ☐ Yes
- Other _____

Skin
- Skin rash ☐ No ☐ Yes
- Boils ☐ No ☐ Yes
- Persistent rash ☐ No ☐ Yes
- Other _____

Musculoskeletal
- Muscle weakness ☐ No ☐ Yes
- Joint pain ☐ No ☐ Yes
- Back pain ☐ No ☐ Yes
- Other _____

Ear/Nose/Throat/Mouth
- Headache ☐ No ☐ Yes
- Sinus problems ☐ No ☐ Yes
- Other _____

Genitourinary
- Urine retention ☐ No ☐ Yes
- Painful urination ☐ No ☐ Yes
- Urinary frequency ☐ No ☐ Yes
- Urinary urgency ☐ No ☐ Yes
- Urinary leakage ☐ No ☐ Yes
- Other _____

Respiratory
- Wheezing ☐ No ☐ Yes
- Frequent cough ☐ No ☐ Yes
- Shortness of breath ☐ No ☐ Yes
- Other _____

Hematologic/Lymphatic
- Swollen glands ☐ No ☐ Yes
- Bruises ☐ No ☐ Yes
- Other _____

Psychologic
- Depression ☐ No ☐ Yes
- Crying ☐ No ☐ Yes
- Other _____

THE FOLLOWING STANDARDIZED QUESTIONNAIRES DIAGNOSE/SCREEN FOR PELVIC FLOOR DISORDERS AND MAY ADDRESS THE SAME CONDITION IN REPETITION.
PLEASE FILL THE QUESTIONNAIRES OUT ENTIRELY TO ENHANCE OUR CARE FOR WOMEN AFFECTED BY THESE SENSITIVE QUALITY-OF-LIFE DISORDERS.

1. How often do you experience urinary leakage?
   - ☐ Never
   - ☐ Less than once a month
   - ☐ A few times a month
   - ☐ A few times a week
   - ☐ Every day and/or night

2. How much urine do you lose each time?
   - ☐ Drops
   - ☐ Small splashes
   - ☐ More

Pelvic Floor Distress Inventory (PFDI-20)

1. Do you usually experience *pressure* in the lower abdomen? ☐No; ☐ **Yes**
   If **yes**, how much does this bother you?
   ☐**1** ☐**2** ☐**3** ☐**4**
   Not at All - Somewhat - Moderately - Quite a bit

2. Do you usually experience *heaviness or dullness* in the pelvic area? ☐No; ☐ **Yes**
   If **yes**, how much does this bother you?
   ☐**1** ☐**2** ☐**3** ☐**4**
   Not at All - Somewhat - Moderately - Quite a bit

3. Do you usually have a bulge or something falling out that you can see or feel out that you can see or feel in the vaginal area? ☐No; ☐ **Yes**
   If **yes**, how much does this bother you?
   ☐**1** ☐**2** ☐**3** ☐**4**
   Not at All - Somewhat - Moderately - Quite a bit

4. Do you usually have to push on the vagina or around the rectum to have or Complete a bowel movement? ☐No; ☐ **Yes**
   If **yes**, how much does this bother you?
   ☐**1** ☐**2** ☐**3** ☐**4**
   Not at All - Somewhat - Moderately - Quite a bit

5. Do you usually experience a feeling of incomplete bladder emptying? ☐No; ☐ **Yes**
   If **yes**, how much does this bother you?
   ☐**1** ☐**2** ☐**3** ☐**4**
   Not at All - Somewhat - Moderately - Quite a bit

6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination? ☐No; ☐ **Yes**
   If **yes**, how much does this bother you?
   ☐**1** ☐**2** ☐**3** ☐**4**
   Not at All - Somewhat - Moderately - Quite a bit

7. Do you feel you need to strain too hard to have a bowel movement? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

8. Do you feel you have not completely emptied your bowels at the end of a bowel movement? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

9. Do you usually lose stool beyond your control if your stool is well formed? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

10. Do you usually lose stool beyond your control if your stool is loose or liquid? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

11. Do you usually lose gas from the rectum beyond your control? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

12. Do you usually have pain when you pass your stool? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

14. Does a part of your bowel ever pass through the rectum and bulge during or after a bowel movement? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

15. Do you usually experience frequent urination? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

16. Do you usually experience urine leakage associated with a feeling of urgency, that is a strong sensation of needing to go the bathroom? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

17. Do you usually experience urine leakage related to coughing, sneezing or laughing? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

18. Do you usually experience small amounts of urine leakage (that is, drops)? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

19. Do you usually experience difficulty emptying your bladder? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

20. Do you usually experience *pain* or *discomfort* in the lower abdomen or genital region? ☐No; ☐ **Yes**

If **yes**, how much does this bother you?

☐**1** ☐**2** ☐**3** ☐**4**

Not at All - Somewhat - Moderately - Quite a bit

Pelvic floor Impact Questionnaire (PFIQ-7)

INSTRUCTIONS: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question, place an X in the response that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions over the last 3 months. Please be sure to mark an answer in all 3 columns for each question.

How do symptoms or conditions relating to the following →→→→ Usually affect your ↓	Bladder or urine	Bowel or rectum	Vagina or pelvis
1. ability to do household chores (cooking, housecleaning, laundry)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
2. ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
3. entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
4. ability to travel by car or bus for a distance of greater than 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

5. participating in social activities outside your home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
6. emotional health (nervousness, depression, etc.)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
7. feeling frustrated?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit