

Patient History Questionnaire

Patient Name: _____

DOB: _____

Date: _____

Past Medical History

- | | | | |
|-------------------------------|------------------------------|--------------------------|------------------------------|
| No medical history | ☐ | | |
| Anemia | ☐ Yes | Urinary Disorder | ☐ Yes |
| Complications with Anesthesia | ☐ Yes | Immunological Disease | ☐ Yes |
| Cancer | ☐ Yes | Heart Disease | ☐ Yes |
| Diabetes | ☐ Yes | Kidney Disease | ☐ Yes |
| Endometriosis | ☐ Yes | Lung Disease | ☐ Yes |
| Fibromyalgia | ☐ Yes | Liver Disease | ☐ Yes |
| Hepatitis | ☐ Yes | Neurological Disease | ☐ Yes |
| Stroke | ☐ Yes | Psychiatric Illness | ☐ Yes |
| Bleeding/Clotting Disorder | ☐ Yes | Gastrointestinal Disease | ☐ Yes |
| Thyroid Issues | ☐ Yes | | |

Notes: _____

Surgical History

- | | | |
|--|------------------------------|-------------|
| No surgical history | ☐ | |
| Have had any of the following surgeries? | ☐ Yes | |
| Hysterectomy | ☐ Yes | Date: _____ |
| Colon Surgery | ☐ Yes | Date: _____ |
| Endometriosis Surgery | ☐ Yes | Date: _____ |
| Bladder Botox | ☐ Yes | Date: _____ |

Axonics ☐ Yes Date: _____

Urgent PC ☐ Yes Date: _____

Prolapse Repair ☐ Yes Date: _____

Removal of tubes/ovaries ☐ Yes Date: _____

Sling ☐ Yes Date: _____

Other Surgeries/Date:

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Alcohol Use ☐ Yes

Number of Drinks / Week: _____

Recreational Drug Use ☐ Yes

Smoking Status: ☐ Current ☐ Former ☐ Never

Occupation: _____

Family History

Diabetes: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Heart Disease: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

High Blood Pressure: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Kidney Disease: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Stroke: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Cancer: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

BRCA positive: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Bleeding/Clotting disorders: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Breast Cancer: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Ovarian cancer: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Notes: _____

Medications History - have you ever taken any of the following:

Oxybutynin	☐ Yes	Tolterodine	☐ Yes
Solifenacin	☐ Yes	Mirabegron	☐ Yes
Fesoterodine	☐ Yes	Gemtesa	☐ Yes
Darifenacin	☐ Yes	Oxytrol	☐ Yes
Gelnique	☐ Yes		

*******Please List Other Current Medications*******

Allergic History

No Known Drug Allergy ☐ Yes

Drug Allergy/Reaction: _____

Non-Drug Allergy/Reaction: _____

Type of reaction: _____

Gyn History

Are you menopausal? ☐ Yes

Are you sexually active? ☐ Yes

Are you using contraception? ☐ Yes

Type of contraception: _____

How many babies: _____

of vaginal deliveries: _____

of C-Section: _____

Sexually Transmitted Disease ☐ Yes

Type of Sexually Transmitted Disease: _____