Georgia Center for Pelvic Health

Female Urology and Sexual Health Intake Form

☐ **Samantha S. Tojino, FNP-C** ☐ **Dr. Conrado N. Tojino, Jr.**

Date:_____ Age: _____ Time In: _____ Time Out: _____

Last Name: _____ First Name: _____ DOB_____

Vitals: Temp:_____ B/P: _____ Pulse: _____ Resp. _____ Wgt: _____Hgt:_____BMI:_____

Referring Physician
Name: _____

Address: _____

City _____ State _____ Zip_____

Primary Care Physician
Name: _____

Address: _____

City_____ State_____ Zip_____

☐ **Today's Visit** ☐ **New Patient Visit** **Established Visit**

CHIEF COMPLAINT

What is the main reason you came to the office today?

_____
_____
_____

When did it start? _____

What treatments have you had so far for this health issue?

_____
_____

HISTORY OF MEDICAL CONDITIONS:

Please list any and all current medical conditions you may have:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

SURGICAL HISTORY

Please list all past surgeries and dates:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list any allergies (food, medications, etc.) and your reaction to them:

ALLERGIES	Reaction
_____	_____
_____	_____
_____	_____

Please list or attach a list of your current medications, dose and how often you take them (this includes birth control, hormone replacement meds, vitamins, and supplements).

MEDICATION LIST	Dose	Frequency (schedule)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever taken Birth Control Pills in the past? _____ Yes ____ No How many years ago? _____

Please indicate date and place for the following procedures. If a procedure does not apply to you, select "No".

Procedure			Date	Result
PAP SMEAR	☐ Yes	☐ No	_____	_____
COLONOSCOPY	☐ Yes	☐ No	_____	_____

OBSTETRICAL HISTORY:

How many times have you been pregnant? _____

Of these pregnancies, how many were…

Preterm (premature) deliveries _____
Full term deliveries _____
Miscarriages or abortions _____
Cesarean delivery _____
Forceps or vacuum _____

GYNECOLOGICAL HISTORY:

What was the first day of your last menstrual period? _____ Are you sexually active? ☐ Yes ☐ No

Do you have pain with intercourse? ☐ Yes ☐ No Circle all that apply: Pain with Penetration or Pain with Deep Penetration

Please check any of the following that you **CURRENTLY** are experiencing or have experienced in the past.

☐ Heavy menstruation ☐ Fibroids (myomas) ☐ Irregular bleeding

☐ Sexually transmitted infection (gonorrhea, chlamydia, herpes) ☐ Abnormal pap smear

☐ Pelvic infection (PID) ☐ Yeast infection ☐ Ovarian cysts or tumors

☐ Vaginal dryness ☐ Decreased libido/desire ☐ Inability or difficulty achieving orgasm

☐ Pelvic pain ☐ Decreased arousal ☐ Persistent genital arousal

SOCIAL HISTORY:

Are you? ☐ Single ☐ Married Number of years _____ ☐ Divorced ☐ Widowed

Who do you live with? _____

Do you work? ☐ Yes ☐ No What is your current or most recent job? _____

Do you exercise? ☐ Yes ☐ No Describe you current exercise routine _____

Do you smoke? ☐ Yes ☐ No If yes, how many per day? ☐ 5 ☐ 10 ☐ 20 (one pack) ☐ More than 20 # of years?_____

How often do you drink alcohol? ☐ Never ☐ Daily ☐ Weekly ☐ Occasionally

Do you use any other drugs? ☐ Yes ☐ No Please list _____

During the past month, have you been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No

Have you ever been emotionally, physically, or sexually abused? ☐ Yes ☐ No

If yes, by whom? _____ When? _____

FAMILY HISTORY:

Have any of your relatives had any of the following illnesses?

Diabetes ☐ Yes ☐ No Who?_____ Stroke ☐ Yes ☐ No Who? _____

Asthma ☐ Yes ☐ No Who? _____ Migraines ☐ Yes ☐ No Who? _____

Hypertension ☐ Yes ☐ No Who? _____ Heart Disease ☐ Yes ☐ No Who? _____

Kidney Disease ☐ Yes ☐ No Who? _____ Mental disease ☐ Yes ☐ No Who? _____

Cancer ☐ Yes ☐ No Who and what type? _____

CURRENT UROLOGICAL COMPLAINTS

Do you experience leakage of urine? ☐ Yes ☐ No If yes, how long? _____ months _____ years

After you urinate, do you have dribbling? ☐ Yes ☐ No

Do you leak when you cough, sneeze, or laugh? ☐ Yes ☐ No

Do you leak urine on the way to the bathroom? ☐ Yes ☐ No

Please check if you leak urine during the following times?

☐ Walking ☐ Running ☐ Urgency ☐ Changing from sitting to standing ☐ Exercise

☐ Straining or lifting ☐ With Intercourse ☐ Lying Down ☐ Minimal activity

Do you use a pad for urine leakage? ☐ Yes ☐ No If yes, how many per day? _____

Do you ever wet the bed while sleeping? ☐ Yes ☐ No

What amount of leakage do you experience? ☐ Drops ☐ More than drops ☐ Leak Continually ☐ Flood

UROLOGICAL HISTORY

Number of urinary tract infections in the past year? _____

Any blood in urine? ☐ Yes ☐ No Any kidney infections (pyelonephritis)? ☐ Yes ☐ No

Do you find it hard to start to urinate? ☐ Yes ☐ No Any history of kidney stones? ☐ Yes ☐ No

Did you have childhood urinary problems? ☐ Yes ☐ No Have you ever had a urinary catheter? ☐ Yes ☐ No

After emptying your bladder, do you feel like you need to go again? ☐ Yes ☐ No

How many times per day do you urinate? _____ How many times do you get up to urinate after going to bed? _____

Bowel Habits

Diarrhea ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Laxative Use ☐ Yes ☐ No
Do you strain with bowel movements? ☐ Yes ☐ No
Do you use a finger in the vagina to assist with bowel movements? ☐ Yes ☐ No

SEXUAL HISTORY

Sexually active ☐ Yes ☐ No How often? _____ / wk _____/ month. Distress level 0-10 scale_____
Do you experience orgasm ☐ Yes ☐ No Clitoral stimulation _____ Vaginal penetration_____
Are you able to experience orgasm with self-stimulation? ☐ Yes ☐ No Never experienced an orgasm? ☐ Yes ☐ No
Is this experience a new onset? ☐ Yes ☐ No Diminished interest/desire ☐ Yes ☐ No
Do you experience diminished ability to concentrate? ☐ Yes ☐ No
Do you ever have sexual fantasies or erotic thoughts? ☐ Yes ☐ No Who initiates sexual activity? ☐ Partner ☐ Self ☐ Both

REVIEW OF SYSTEMS

Please indicate whether each of the following is currently a concern for you.

General

Excessive fatigue ☐ Yes ☐ No
Weight loss ☐Yes ☐ No
Excessive thirst ☐ Yes ☐ No
Lumps or swelling ☐ Yes ☐ No
Weight gain ☐ Yes ☐ No
Depression ☐ Yes ☐ No

Skin/Hair

Rash ☐ Yes ☐ No
Recurrent sores ☐ Yes ☐ No
Moles that have changed in color ☐ Yes ☐ No
Swollen glands ☐ Yes ☐ No
Hair loss ☐ Yes ☐ No

Eyes, Ear, Nose, & Mouth

Hearing difficulty ☐ Yes ☐ No
Ringing in the ear ☐ Yes ☐ No
Change in vision ☐ Yes ☐ No
Hoarseness ☐ Yes ☐ No
Change in voice ☐ Yes ☐ No
Difficulty swallowing ☐ Yes ☐ No
Corrective Lens ☐ Yes ☐ No

Heart

Chest pain ☐ Yes ☐ No
Heart palpitations (irregular beat) ☐ Yes ☐ No
Chest discomfort with exercise ☐ Yes ☐ No
Shortness of Breath with walking ☐ Yes ☐ No
Shortness of breath climbing stairs ☐ Yes ☐ No
Anemia ☐ Yes ☐ No

Breast

Lumps ☐ Yes ☐ No
Tenderness ☐ Yes ☐ No
Swelling ☐ Yes ☐ No
Nipple discharge ☐ Yes ☐ No
Skin changes ☐ Yes ☐ No

Nervous System

Frequent or severe headaches ☐ Yes ☐ No
Dizziness ☐ Yes ☐ No
Fainting ☐ Yes ☐ No
Recurrent hand/feet numbness ☐ Yes ☐ No
Mood swings ☐ Yes ☐ No
Depression/Anxiety ☐ Yes ☐ No

Lungs

Shortness of breath ☐ Yes ☐ No
Cough ☐ Yes ☐ No
Wheezing ☐ Yes ☐ No
Coughing up blood ☐ Yes ☐ No

Urinary

Pain with urination ☐ Yes ☐ No
Excessive urinating at night ☐ Yes ☐ No
Bladder infections ☐ Yes ☐ No
Leakage of urine ☐ Yes ☐ No
Kidney stones ☐ Yes ☐ No

Gastrointestinal

Poor appetite	☐ Yes	☐ No
Nausea & Vomiting	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Black, tarry stool	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No

Gynecological

Heavy bleeding	☐ Yes	☐ No
Bleeding between periods	☐ Yes	☐ No
Irregular periods	☐ Yes	☐ No
Pelvic pain	☐ Yes	☐ No
Vaginal sores or ulcers	☐ Yes	☐ No
Vaginal discharge	☐ Yes	☐ No
Foul smelling odor	☐ Yes	☐ No
Pain after sex	☐ Yes	☐ No
Pain with sex	☐ Yes	☐ No
Bleeding with sex	☐ Yes	☐ No

PHYSICAL EXAM

LABS

TT ____ E2 _____ SHBG _____ P4 _____ TSH_____ Prolactin____ FSH____ LH_____ ALT_____ AST_____ CFT____

VITALS

VULVOSCOPY

Hair Distribution: ☐ Full Thickness Distribution ☐ Shaven ☐ Thinning

Notes:

_____
_____
_____
_____

☐**Epithelium**: ☐ Pale ☐ Pink ☐ Bleeds with light touch ☐ Intact Elastic ☐ Inelastic Dry ☐ Moist ☐

Labia: Resorption ☐ **L:_____R:_____** Fissures ☐ Pustules ☐ Vesicles ☐ Papules ☐

Vulvar Pain: Mons Pubis_____ Labia Majora_____ Labia Manora_____

Vestibule: Skene's R___ L___ Minor Vestibular R___ L____ Bartholin R____ L___ Clitoral size _____

Vaginal introitus: _____ Atrophy: _____
Rugae ☐ Present ☐ Absent **Anal wink present** ☐ **Absent** ☐ **Pelvic Floor Muscles: _____**

Urethra: Caruncle ☐ Prolapse ☐ Hypermobility ☐ Leakage with Valsalva maneuver ☐

Cystocele: Staging _____ Rectocele: Staging _____

Impression:

_____
_____
_____
_____
_____
_____
_____

Counseling: _____ > 50% of total visit dedicated to counselling.
PLAN:

_____
_____
_____
_____
_____
_____

Provider Signature: _____ **Supv. Physician: _____**