UROLOGY ASSOCIATES of Green Bay

FEMALE UROLOGY INTAKE FORM

Patient Name: _____ Date Of Birth: _____

Date of Visit: ___/___/___ **Primary Care Physician**: _____

Overactive Bladder Symptom Score, Circle your answers and add up your scores at the bottom

	0	**1**	**2**	**3**	**4**	**5**
How many times do you typically urinate from waking in the morning until sleeping at night?	**≤7**	**8-14**	**≥ 15**			
How many times do you typically wake up to urinate from sleeping at night until waking in the morning?	**0**	**1**	**2**	**≥ 3**		
How often do you have a sudden desire to urinate, which is difficult to defer?	Not at all	Less than once a week	Once a week or more	About once a day	2-4 times a day	5 times a day or more
How often do you leak urine because you cannot defer the sudden desire to urinate?	Not at all	Less than once a week	Once a week or more	About once a day	2-4 times a day	5 times a day or more
Add Symptom Scores						

Total score for questions above = _____

QUALITY OF LIFE	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Do you have accidental bowel leakage? Yes / No
Do you have difficulty emptying your bladder? Yes / No
Do you experience accidental leakage when performing some physical activity such as coughing, sneezing, laughing, or exercising? Yes / No
Have you tried medications to help improve your symptoms? Yes / No
Have you tried a short term therapy such as Botox or PTNS? Yes / No
Would you be interested in learning more about a long lasting procedural option that may help you with your symptoms? Yes / No

Women's Hormone & Sexual Health Questionnaire

What Brings You In Today? (Check all that apply)

- ❑ Not feeling like myself
- ❑ Fatigue/low energy
- ❑ Brain Fog
- ❑ Mood Changes (anxiety, depression, emotional numbness, crying spells, loss of interest)
- ❑ Hot flashes or night sweats
- ❑ Sleep problems (trouble falling asleep, staying asleep, or waking feeling unrefreshed)
- ❑ Low sexual desire
- ❑ Difficulty with arousal
- ❑ Difficulty with orgasm
- ❑ Pain with sex
- ❑ Recurrent urinary symptoms

Not Feeling Like Myself (NFLM) Score:
0= not at all myself, 10= completely myself
NFLM Score: _____/10

What would "feeling better" look like for you? _____
_____

Sexual Health- In the past 3 months:
Has your interest in sex changed? Improved / Worse / About the Same
How distressing is your level of sexual desire? Not distressing / Mildly / Moderately / Severely
Is sexual activity important to you? Yes / No / Unsure
Do you avoid sexual activity because of pain or discomfort? Yes / No

- If yes: Does pain occur with penetration? Yes / No
  - Burning or irritation? Yes / No
  - Vaginal dryness? Yes / No
  - Pain after intercourse? Yes / No

Menstrual and Reproductive History
Age of first menstruation: _____
Menstrual status: Regular / Irregular / Perimenopausal / Postmenopausal
Date of last menstrual period (if applicable): _____
Number of pregnancies: _____ Vaginal Births: _____ Cesareans: _____
Have you had a hysterectomy? Yes / No

- If yes: Are your ovaries still present? Yes / No

Current Medications: (Check all that apply)

- ❑ Antidepressants
- ❑ Hormonal Birth Control
- ❑ Estrogen
- ❑ Progesterone
- ❑ Testosterone
- ❑ Supplements