SHENANDOAH
MEDICAL CENTER

WOMEN'S CENTER

Dr. Michael Woods - M.D, F.A.C.O.G
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1 Jack Foster Drive
Shenandoah, Iowa 51601
(712) 246-7400 - Phone
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Name: _____ Date of Birth: _____

Please explain the reason why you are here today:

_____

_____

_____

Who referred you? _____

Primary Physician: _____ Address: _____

Obstetrical History: Number of Pregnancies: ____ Births: ____ Miscarriages: ____

Vaginal Births: ____ Cesarean: ____ Forceps? □ Yes □ No "Tears?" □ Yes □ No

Gynecologic History: Last Pap smear? _____ Any abnormal? □ Yes □ No

How long ago? _____ Treatment? _____

Last menstrual period: _____ Menopause? □ Yes □ No □ Natural □ Hysterectomy

Have you had a hysterectomy? □ Yes □ No □ Vaginal □ Abdominal

Have you ever had a sexually transmitted infection? _____

Any surgery for urinary incontinence? _____

Any surgery for pelvic organ prolapse? _____

Surgical History: Please list any surgeries or procedures you have had:

Surgery	Year	Reason	Complications?

Medical History: Do you have (past or present) any of the following?

- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV (AIDS)
- ☐ Allergies
- ☐ Asthma
- ☐ Heart Disease
- ☐ Weight Problems
- ☐ Acid Reflux
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Glaucoma
- ☐ Depression/Anxiety
- ☐ M.S. or other neurologic problem
- ☐ Alcoholism
- ☐ Drug addiction
- ☐ Bleeding Problems/blood clots
- ☐ Other: _____

Allergies: Do you have any drug allergies or sensitivities?

Drug	Reaction	Drug	Reaction

Medications: Please list all medications, vitamins and supplements.

Drug	Dose	Reason for taking	Taken as prescribed? Y / N

Pharmacy _____

Have you previously tried any of the following medications (circle all that apply)?

Ditropan (Oxybutynin)
Vesicare (Solifenacin)
Sanctura (Trospium Chloride)
Detrol LA (Tolterodine)
Toviaz (Fesoterodine)
Enablex (Darifenacin)
Myrbetriq (Mirabegron)

Social History:

□ Married □ Divorced □ Widowed □ Single

Are you currently sexually active? □ Yes □ No

Do you have pain with sexual activity? □ Yes □ No Explain: _____

Are you satisfied with your current level of sexual activity? □ Yes □ No

Do you work? □ Yes □ No □ Retired Occupation? _____

Do you currently smoke? □ Yes □ No

Have you ever smoked? □ Yes □ No How long? _____ Packs per day _____

Do you use any illicit drugs? _____

Drink alcohol? □ Yes □ No What kind/how often? _____

Have you ever been (circle all that applies)?

Physically / emotionally / verbally / sexually.....abused? □ In the past □ Currently

Family History:

Does anyone in your family (mother/father/sister/brother) have any of the following?

Breast Cancer _____ Colon Cancer _____

High Blood Pressure _____ Diabetes _____

Heart Disease _____ Problems with anesthesia _____

Blood clots _____ Stroke _____

Bleeding problems _____

Incontinence Impact Questionnaire– Short Form IIQ-7

Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activity, relationships, and feelings are being affected by urine leakage.

Has urine leakage affected your...

	Not at All	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3
2. Physical recreation such as walking, swimming, or other exercise?	0	1	2	3
3. Entertainment activities (movies, concerts, etc.)?	0	1	2	3
4. Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
5. Participation in social activities outside your home?	0	1	2	3
6. Emotional health (nervousness, depression, etc.)?	0	1	2	3
7. Feeling frustrated?	0	1	2	3

Items 1 and 2 = physical activity
Item 5 = social/relationships
Items 3 and 4 = travel
Items 6 and 7 = emotional health

Scoring. Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

Reference. Uebersax, J.S., Wyman, J. F., Shumaker, S. A., McClish, D. K., Fantl, J. A., & the Continence Program for Women Research Group. (1995). Short forms to assess life quality and symptom distress for urinary incontinence in women: The incontinence impact questionnaire and the urogenital distress inventory. *Neurourology and Urodynamics, 14,* 131-139.

MESA Questionnaire

	Never	Rarely	Sometimes	Often
Stress Symptoms	0	1	2	3
Does coughing gently cause you to lose urine?	0	1	2	3
Does coughing hard cause you to lose urine?	0	1	2	3
Does sneezing cause you to lose urine?	0	1	2	3
Does lifting things cause you to lose urine?	0	1	2	3
Does bending cause you to lose urine?	0	1	2	3
Does laughing cause you to lose urine?	0	1	2	3
Does walking briskly or jogging cause you to lose urine?	0	1	2	3
Does straining, if constipated, cause you to lose urine?	0	1	2	3
Does getting up from a sitting to a standing position cause you to lose urine?	0	1	2	3
Urge Symptoms				
Some women receive very little warning and suddenly find that they are losing, or about to lose urine beyond their control. How often does this happen to you?	0	1	2	3
If you can't find a toilet or find that the toilet is occupied, and you have the urge to urinate, how often do you end up losing urine or wetting yourself?	0	1	2	3
Do you lose urine when you suddenly have the feeling that your bladder is very full?	0	1	2	3
Does washing your hands cause you to lose urine?	0	1	2	3
Does cold weather cause you to lose urine?	0	1	2	3
Does drinking cold beverages cause you to lose urine?	0	1	2	3

Additional Questions

How long have these symptoms been present?

How often does your bladder leak urine because of these symptoms (stress or urge)?

Of these two types of leakage, which one bothers you the most?

Please answer all of the questions in the following survey. These questions will ask you if you have certain bladder, pelvic or bowel symptoms and, if you do how much they bother you. Answer these by marking the appropriate number. While answering these questions, please consider your symptoms over the last 3 months. The PFDI- 20 has 20 items and 3 scales for your symptoms. All items use the following format with a response scale from 0-4.

Symptoms Present = YES, scale of bother:

1 = Not at All 2 = Somewhat 3 = Moderately 4 = Quite a Bit 0 = Not Present

Symptoms NOT Present = NO

Pelvic Organ Prolapse Distress Inventory 6

Do you...

	No	Yes
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal Distress Inventory 9

Do you...

	No	Yes
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary Distress Inventory 6

Do you...

	No	Yes
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing, or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

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T: (712) 246-7400 F: (712) 246-7340 Name:_____ Date:_____

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Comprehensive Health Assessment

Do you have any difficulty with any of the following?

Hearing? ☐ No. I have normal hearing. ☐ Yes

If yes, circle one: Difficulty hearing, left ear Difficulty hearing, right ear Deafness, left ear Deafness, right ear

Vision? ☐ No. I have normal vision. ☐ Yes

If yes, circle one: Difficulty seeing, left eye Difficulty seeing, right eye Blindness, left eye Blindness, right eye

Ambulation? ☐ No. I have normal ambulation. ☐ Yes, I have difficulty walking.

Difficulty with stairs? ☐ No ☐ Yes

If yes, circle one: Difficulty climbing up stairs Difficulty going down stairs

Activities of Daily Living? ☐ No. I have normal ADLS. ☐ Yes.

If yes, circle one: Difficulty bathing Difficulty dressing

Independent Activities? ☐ No, I do not have any difficulty doing errands alone. ☐ Yes, I have difficulty doing errands alone.

Cognition? ☐ No. I have normal cognition. Yes. ☐

If yes, circle one: Difficulty concentrating Difficulty making decisions Difficulty remembering

Speech? ☐ No. I have normal speech. ☐ Yes. Please explain below

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Do you have an advanced directive or living will? ☐ No Would you like information about this today? Yes ☐ No ☐
☐ Yes Do we have a copy on file? ☐ Yes ☐ No

What is your preferred spoken language?

☐ English ☐ Spanish ☐ Chinese ☐ Filipino ☐ French ☐ German ☐ Italian
☐ Korean ☐ Russian ☐ Vietnamese ☐ Sign

What is your preferred reading language?

☐ English ☐ Spanish ☐ Chinese ☐ Filipino ☐ French ☐ German
☐ Korean ☐ Russian ☐ Braille ☐ Vietnamese ☐ Italian

Who do you live with?

☐ Alone ☐ Adult Child(ren) ☐ Dependent Child(ren) ☐ Domestic partner
☐ Grandparents ☐ Relatives (Specify) ☐ Parents ☐ Sibling(s) ☐ Friends
☐ Significant other ☐ Spouse ☐ Other_____

What are your living arrangements?

☐ Apartment ☐ Assisted Living ☐ Condominium ☐ Correctional Facility ☐ Residential/Group Home
☐ Hospice Care Facility ☐ House ☐ Independent living ☐ Mobile Home ☐ Nursing Home
☐ Shelter/ No permanent address (explain in comments) ☐ Homeless (explain in comments)

Comments:_____

Employment Status:

☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Homemaker ☐ Self-employed ☐ Student

Relationship Status:

☐ Single ☐ Committed Relationship ☐ Domestic Partnership ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Are you satisfied with your friends/family relationships? ☐ Yes ☐ No (Explain in comments)

Comments:_____

Do you feel safe where you live? ☐ Yes ☐ No (Explain in comments)

Comments:_____

Are you sexually active? ☐ Yes ☐ No ☐ N/A **If yes, do you practice safe sex?** ☐ Yes ☐ No

Do you have a good support system? ☐ Yes ☐ No (Explain in comments)

Comments:_____

Do you see a dentist? ☐ Yes ☐ No (Explain in comments) Comments:_____

If yes, name of dentist and date of last visit. Name:_____ Date:_____

Do you have enough money for food? ☐ Yes ☐ No (Explain in comments) Comments:_____

Significant Exposure: None Fumes Dust Solvents ☐ Airborne particles Noise ☐ Secondhand Smoke

Family history of mental/behavioral health/substance abuse disorders? ☐ Yes ☐ No

If yes, please list :_____

Lifestyle Lead: ☐ Sedentary ☐ Active **Do you exercise regularly?** Yes ☐ No ☐

Can you afford your medications? ☐ Yes ☐ No (Explain in comments) Comments:_____

Are you a high School graduate or have your GED? ☐ Yes ☐ No If no, highest grade completed?_____

Do you have a college education? ☐ Yes ☐ No If no, highest grade completed?_____

Do you have transportation? ☐ Own vehicle ☐ Family/Friends ☐ Community transportation/Taxi ☐ None

Comments:_____

Do you smoke or have you ever smoked? ☐ Yes ☐ No

If yes, circle one: Current every day smoker Current some day smoker Light smoker Heavy smoker Former smoker

How many cigarettes do you smoke per day (# of packs) _____ **How long have you smoked (in years)?** ____

How would you rate your readiness to quit smoking? Circle one. Ready to quit Thinking about it Not ready

Would you like any information about quitting today? ☐ Yes ☐ No

Do you use any other forms of tobacco? ☐ Yes ☐ No **If yes, circle one:** chewing tobacco cigar pipe e-cigarette

How would you rate your readiness to quit? Circle one. Ready to quit Thinking about it Not ready

Would you like any information about quitting today? ☐ Yes ☐ No

Do you drink alcohol or have you ever drank alcohol? ☐ Yes ☐ No **If yes, circle one:** currently past

Do you drink caffeinated beverages? ☐ Yes ☐ No **If yes, circle one:** coffee tea pop/soda energy drinks

If yes, how many caffeinated drinks (cups/cans) per day? Circle one. occasional use 1-2 3-4 5-6 7-9 10 or more

Do you currently or have you ever used street drugs, inhalants, or abused prescription medications? ☐ Yes ☐ No

If yes, what type? Circle one. amphetamines cocaine depressants ecstasy hallucinogens heroin marijuana methamphetamine narcotics PCP (phencyclidine) sedatives steroids stimulants inhalants (solvents, gases, nitrites, aerosols)

If yes, circle a route of administration: intravenous (IV) oral smoking snorting

If yes, how frequently? Circle one. monthly or less 2-4 times/month 2-3 times/week 4 or more times/week daily

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns			+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

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Name _____
Height _____ Weight _____
Age _____ Male / Female _____

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel TIRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

High risk of OSA: Yes 5 - 8

Intermediate risk of OSA: Yes 3 - 4

Low risk of OSA: Yes 0 - 2