UROGYNECOLOGY Consultants

UROGYNECOLOGIC HISTORY

CAROL A. GRAHAM M.D.

***Fill in highlighted areas only**

Primary Care Physician's name_____ Referring Physician's name_____

Weight_____ Gravidity_____
Height_____ Vaginal Parity_____
Age_____ LMP_____ C/S_____

Drug allergies_____
_____
_____

Previous surgeries_____
_____
_____
_____

TEST	DATE	RESULT
PAP		
MAMMOGRAM		
COLONOSCOPY		
	Current Medications	
MED	DOSE	Schedule

Hyst _____ 0-None 1-Vaginal 2-Abdominal
Ovaries_____ 0-Present 1-USO 2-BSO
Prior continence surgery Y N
#Continence surgeries_____
Type of continence surgery 0=None 1=ANT Repair 2=Needle 3=RPU 4=Other
Prior Prolapse Surgery Y N # Prolapse surgeries_____
Type of Prolapse surgeries 0=none 1-Ant. Repair 2=Posterior Repair 3=A&P Repair 4=SSLS 5=Enterocele Repair
Other_____

OFFICE USE ONLY

CC. (Circle one)
UI Symptoms_____ 0=None 1=GSI 2=DI . 3=MI
Duration (yrs)_____
UI Frequency_____ 0=None 1=<Month 2=Few times/Month 3= Few Times/week 4 Daily or Nightly
UI Severity 0=None 1=Drops 2=Small Splashes 3=More than small splashes
#Pads/Day_____
#Voids/Night_____
#Voids Day_____
Grade of SUI_____

Results of Exam_____
_____

POP
Duration (yrs)_____
UI yes no
Pessary yes no
Comments_____
_____

Constipatation
Duration (yrs)
#BM's wk
Stenting
0=none 1=vagina 2=perineum 3=both
Inc emptying y n

PAST HISTORY ASSESMENT	YES	NO	COMMENT	FAMILY HISTORY	YES	NO
BLOOD DISORDERS/TRANSFUSIONS						
HEPATITIS/TB/AIDS/HIV/OTHER						
DRUG OR ETOH ABUSE						
HEART DISEASE/HTN/CHEST PAIN						
RESPIRATORY DISEASE/ASTHMA/SOB						
CIRCULATORY PROBLEMS						
DIABETES						
CANCER						
MUSCULOSKELETAL PROBLEMS						
SKIN PROBLEMS						
GI PROBLEMS						
GLAUCOMA/CATARACTS/IMPLANTS						
GU/KIDNEY/PROBLEMS						
LIVER/THYROID PROBLEMS						
EMOTIONAL/BEHAVIORAL PROBLEMS						
OTHER PROBLEMS						

PLAN_____