

# Urogynecology outpatient sheet

Patient name: \_\_\_\_\_  Age: \_\_\_\_\_  G/P: \_\_\_\_\_

Chief complaint: \_\_\_\_\_

History of present illness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prolapse symptoms:  Pelvic pressure  Vaginal bulge  Interfere with quality of life

Onset and course: \_\_\_\_\_

Stress incontinence:  Interfere with quality of life

cough  sneezing  lifting  laughing  exercise  sex

Onset and frequency: \_\_\_\_\_

Overactive bladder:  Interfere with quality of life

urgency  frequency  Nighttime Frequency  urge incontinence  Nocturia

Onset and frequency: \_\_\_\_\_

Triggers:  key in the door  change in position  sight or sound of running water

Pads/day \_\_\_\_\_ Pads/night \_\_\_\_\_

Difficult voiding:  incomplete emptying  positional voiding  valsalva voiding

Bowel symptoms:  Interfere with quality of life

frequency -----/day  soft/regular  straining with BM  sensation of stool trapping

Perineal/vaginal splinting  Fecal incontinence

Sexual symptoms:  Interfere with quality of life

Active:  No issues  Dryness  Dyspareunia (superficial/deep)

Inactive: Reason \_\_\_\_\_

UTI history:  Current symptoms \_\_\_\_\_  Recurrent UTIs \_\_\_\_\_

Intake(cup-glass/day):  water  juice  milk  coffee  tea

soda  alcohol

- Menstrual history \_\_\_\_\_
- Obstetric history \_\_\_\_\_
- ROS \_\_\_\_\_
- Past medical history:
  - HTN: \_\_\_\_\_  DM: \_\_\_\_\_  CAD: \_\_\_\_\_  Asthma: \_\_\_\_\_
  - Coag: \_\_\_\_\_  Thyroid: \_\_\_\_\_  Others: \_\_\_\_\_
- Medications:
  - ASA \_\_\_\_\_  Fish oil, Ginko \_\_\_\_\_  Anticoagulation \_\_\_\_\_
- Past surgical history:
  - Hysterectomy: Route \_\_\_\_\_ Year \_\_\_\_\_ Indication \_\_\_\_\_
  - POP repair/UI surgery: \_\_\_\_\_
  - Appendectomy \_\_\_\_\_  Cholecystectomy \_\_\_\_\_
  - Others \_\_\_\_\_
- Social history:
  - Tobacco: \_\_\_\_\_  Alcohol \_\_\_\_\_  Job \_\_\_\_\_
- Family history:
  - Breast \_\_\_\_\_  Ovarian \_\_\_\_\_  Uterine \_\_\_\_\_  Colon \_\_\_\_\_
- Allergies \_\_\_\_\_
- Examination:
  - Urethra: Diverticulum (yes, no) SUI (yes, no) \_\_\_\_\_ Urethral mobility \_\_\_\_\_
  - Cystocele \_\_\_\_\_  Rectocele \_\_\_\_\_  uterine \_\_\_\_\_
  - Atrophy \_\_\_\_\_  Pelvic floor \_\_\_\_\_
  - Uterine size \_\_\_\_\_ weeks  Uterine mobility  Vaginal caliber: narrow – adequate
  - Cervix location: normal, high, prolapsed  Uterine descent: \_\_\_\_\_

<b>Impression:</b>	<u>Pelvic Muscles:</u>
<u>POP:</u>	<input type="checkbox"/> Levator Spasm
<input type="checkbox"/> Cystocele	<input type="checkbox"/> ↓ Tone
<input type="checkbox"/> Uterus/Vault	<u>Bowels</u>
<input type="checkbox"/> Rectocele	<input type="checkbox"/> Constipation
<input type="checkbox"/> Perineocele	<input type="checkbox"/> Defacatory Dysfxn
<u>UI:</u>	<input type="checkbox"/> Loose
<input type="checkbox"/> Stress	<u>Infection</u>
<input type="checkbox"/> Urge	<input type="checkbox"/> UTI
<input type="checkbox"/> Mixed	<input type="checkbox"/> Recurrent UTI

<b>Plan:</b>		
<u>POP:</u>	<u>UI:</u>	<u>Other:</u>
<input type="checkbox"/> Obs	<input type="checkbox"/> Obs	<input type="checkbox"/> Premarin
<input type="checkbox"/> Pessary	<input type="checkbox"/> Pessary	<input type="checkbox"/> Bowel Reg
<input type="checkbox"/> Surgery	<input type="checkbox"/> PT	<input type="checkbox"/> Pelvic Floor PT
	<input type="checkbox"/> Sling	<input type="checkbox"/> Urine Cx
	<input type="checkbox"/> Interstim	

