New Patient Questionnaire for Alexis Chesrow MD, FPMRS

What brings you in today? _____

What have you tried for this in the past? _____

How many times do you urinate during the day? < 5 5-10 10-15 >15 OAB

How many of these daytime urinations are URGENT? < 25% 25% 50% 75% 100%

Do you leak urine on the way to the washroom/comes out before you can sit down? Yes No

Few drops Wet your underwear/pad Soak your clothes/pad UUI

How many times do you wake up from sleep to urinate? 0-1 1-2 2-3 3-4 > 4

Do you leak urine when you wake up to urinate? Yes No NOCTURIA

Do you wake up from sleep already wet? Yes No

Do you leak urine with cough, sneeze, exercise or lifting (now or previously)? Yes No SUI

Few drops Wet your underwear/pad Soak your clothes/pad

Number of pads/pullups/other used during the DAY for leakage? _____

Number of pads/pullups/other used WHILE ASLEEP for leakage?_____

Force of urinary stream? Strong Weak Pause before it starts Starts and stops

Do you feel like you empty your bladder all the way? Yes No Sometimes

Daily Fluids Consumption: Water_____ Coffee_____ Tea_____ Juice_____ Soda_____ POLYDIPSIA

Other/Alcohol_____

Do you feel a sense of prolapse (bulge or ball coming to the vaginal opening)? Yes No PROLAPSE

For how long? _____

Have you tried a pessary? _____

Any change in how you urinate or defecate? _____

Any need to push anything back into the vagina to urinate or defecate? Yes No

Have you had any surgeries for incontinence or prolapse? _____

Previous Urological/Gynecological/Abdominal surgeries including hysterectomy?

_____

How many: Vaginal Births _____ C- Sections _____ Largest Birth Weight _____

Any issues with the deliveries (rapid, prolonged, episiotomy)?_____

Are you sexually active? Yes No

DYSPAREUNIA

If no, would you like to be? Yes No

Any current or previous pain with intercourse? Yes No

Genitourinay Syndrome of Menopause

Any Vaginal: Pain Dryness Itching Skin Changes

Any hormone replacement (vaginal or whole body)?_____

How often do you typically have a bowel movement? _____/Day _____/Week _____/Month

Constipaton

Is your stool: Loose Soft Formed Hard

Any fecal urgency or fecal incontinence episodes? _____/Day _____/Week _____/Month

Fecal urgency/incontinence

Any neurological issues? CVA/TIA/Stroke/Head Injury Back Surgery/Spinal Issues

Memory Issues/Dementia Parkinson's Multiple Sclerosis Anxiety/Depression/Bipolar

_____

Ever see or been told you have blood in the urine? Yes No

Any previous renal stones? Yes No

Passed on their own ESWL(Shock-Wave) Ureteroscopy Ureteral Stent PCNL

Any issues with urinary tract infections/Bladder infections? Yes No

How many in the last 12 months: _____

Any pediatric issues with: urination incontinence constipation UTI

Are you diabetic? Yes No **Last HGA1C value?**_____

Any history of or current: cancer radiation steroid use blood thinners

Current or previous smoker? Yes No For how many years? ____ Max number packs/day? ____

Any significant chemical exposure? _____

Any other major health issues? _____