1135 116th Ave NE
Suite 420
Bellevue, WA 98004
P (425) 635-3450
F (425) 635-3451

Julie LaCombe, MD, FACOG FPMRS
Haily Swinger, MSN, ARNP-BC

Appointment Date

Check-In

PATIENT HISTORY FORM

Note: This is a confidential record that will be shredded upon entry into our electronic health record. Information contained here will not be released to anyone without your authorization to do so.

Last Name: ______________________________ **First Name** ______________________ **Age**: __________

Who referred you to us? ____________________**Who is your primary care provider?** __________________

To whom would you like us to fax your consultation note? ____

How did you hear about OMC Pelvic Health (circle one)? My Primary Care Internet Friends/family ER/urgent care Web Site Other

Chief Complaint: What is the main symptom would you like for us to address today?

____

Have you seen an urologist, gynecologist, urogynecologist or FPMRS specialist before (circle one)? Y N

If yes. please provide information below:

Name of facility: _______________________________________Approximate date of service:______________

Have you had an ultrasound, X-ray, MRI, or CT (CAT) scan of your abdomen or pelvis? (circle one)? Y N

If yes, please list what type (i.e., CT, MRI), and where done (Swedish, Virginia Mason, Overlake etc.):

____

Please list all of your current and past medical diagnoses:

1)____**5)**______________________________________

2)____**6)**______________________________________

3)____**7)**______________________________________

4)____**8)**______________________________________

OVERLAKE MEDICAL CLINICS
PELVIC HEALTH

1135 116th Ave NE
Suite 420
Bellevue, WA 98004
P (425) 635-3450
F (425) 635-3451

SURGICAL HISTORY: Please list your past Surgeries.

Type of Surgery ***Date of Surgery***

1)____

2)____

3)____

4)____

5)____

FAMILY HISTORY: Does anyone in your immediate family (parents, siblings, children) have a history of heart disease, heart attack, diabetes, ovarion cancer, breast cancer, kidney cancer, bladder cancer, colon cancer, or any other serious illnesses?

1)____

2)____

3)____

4)____

5)____

OVERLAKE MEDICAL CLINICS
PELVIC HEALTH

SOCIAL HISTORY:

Tobacco History (circle one)? Never Smoked Current Smoker Age Started: __________

Former Smoker (Age started:______ Quit Date:___________)

Years smoked:________ Number of cigarettes per day (circle one): < ½ pack ½ pack 1 pack > 1 pack

Relationship status (circle one): Single Married Divorced Significant other

How much do you drink per day of the following (best estimate):

Coffee/ Tea/ Caffeine______________________________________

Carbonation (soda, sparkling water)________________________

Water:____

Alcohol:____

OBSTETRICAL HISTORY:

Number of Pregnancies:______ # of Vaginal Deliveries:_______ # of Cesarian Deliveries:________

Date of Delivery (Year)	Type of Delivery (Vaginal, C/S, Forceps, etc)	Birthweight (lb/oz or Kg)	Gender (M/ F)	Complications (Perineal tear, hemorrhage, pre-eclampsia)

GYNECOLOGIC HISTORY

Date of Last PAP Smear: _________________ History of abnormal PAP Smears?:________________

Date of Last Mammogram: _______________ History of abnormal mammogram?:________________

Date of Last Colonoscopy:______________ History of abnormal colonoscopy?:________________

Date of Last Menstrual Cycle: _____________ History of hormone use currently or in the past? Y N

Date of Last Bone Density: ________________

Current Form of Birth Control (circle all that apply): Menopause Abstinence Condoms Pills IUD

Vasectomy Tubal Ligation Other:________

Please write any further comments or things you would like us to know in the space below:

OVERLAKE
MEDICAL CLINICS
PELVIC
HEALTH

Medication list—for your safety, please list all medications that you take along with doses.
Include supplements, topical creams such as steroids or vaginal estrogen, over the counter and prescription medications. If you have some medications that you only take "as needed" please include those too. Because medications we may prescribe can have unsafe interactions with other medications, please provide an accurate list along with dosages below.

1)____

2)____

3)____

4)____

5)____

6)____

7)____

8)____

9)____

10)____

ALLERGIES:

Medication	***Reaction (hives, rash, can't breathe, etc)***
1)____________	**1)**____________________
2)____________	**2)**____________________
3)____________	**3)**____________________
4)____________	**4)**____________________

If we order medications after your visit today what pharmacy would you like to use?

Name of pharmacy: ____________

Location: ____________

OVERLAKE MEDICAL CLINICS PELVIC HEALTH

Pelvic Floor Distress Inventory Questionnaire – Short Form 20

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and if you do how much they bother you. Answer each question by putting an X in the appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the **last three months.**

If yes, how much does it bother you?

		Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience pressure in the lower abdomen?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually experience heaviness or dullness in the lower abdomen?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually experience a feeling of incomplete bladder emptying?	YES ☐ NO ☐	☐	☐	☐	☐
Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	YES ☐ NO ☐	☐	☐	☐	☐
Do you feel you need to strain too hard to have a bowel movement?	YES ☐ NO ☐	☐	☐	☐	☐
Do you feel you have not completely emptied your bowels at the end of a bowel movement?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually lose stool beyond your control if your stool is well formed?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually lose stool beyond your control if your stool is loos or liquid?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually lose gas from your rectum beyond your control?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually have pain when you pass your stool?	YES ☐ NO ☐	☐	☐	☐	☐
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	YES ☐ NO ☐	☐	☐	☐	☐
Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually experience frequent urination?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually experience urine leakage related to laughing, coughing, or sneezing?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually experience small amounts of urine leakage (that is, drops)?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually experience difficulty emptying your bladder?	YES ☐ NO ☐	☐	☐	☐	☐
Do you usually experience pain or discomfort in the lower abdomen or genital region?	YES ☐ NO ☐	☐	☐	☐	☐

Urogenital Distress Inventory. For each question, circle the best response.

Do you experience, and if so, how much are you bothered by…	**Not at all**	**Slightly**	**Moderately**	**Greatly**
Frequent urination	0	1	2	3
Leakage related to feeling of urgency	0	1	2	3
Leakage related to physical activity, coughing, or sneezing	0	1	2	3
Small amounts of leakage (drops)	0	1	2	3
Difficulty emptying bladder	0	1	2	3
Pain or discomfort in lower abdominal or genital area	0	1	2	3