Newport Urogynecology
restoring total health for women

INITIAL PATIENT CONSULTATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Height: _____ Weight: _____

Name of referring physician: _____

Physician's Address: _____

Describe the reason(s) for your visit:

_____

_____

_____

Obstetrical History:

Number of pregnancies: _____ Number of living children: _____

Type of Delivery: Vaginal _____ Age at first vaginal delivery: _____

C-section _____

Gynecological History:

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

Date of last menstrual period: _____

Are your periods regular? Yes ☐ No ☐

Your periods last how long? _____ Days

Amount of Flow: Light ☐ Normal ☐ Heavy ☐

Do you have pain with your periods? No ☐ Yes ☐

Do you experience PMS symptoms? No ☐ Yes ☐

If you are menopausal:

Symptoms of hot flashes, vaginal dryness No ☐ Yes ☐

Are you currently taking hormone therapy? No ☐ Yes ☐

Newport Urogynecology - Newport Lido Medical Center
361 Hospital Road, Suite 324, Newport Beach, CA 92663
Telephone: (949) 548-3441 Fax: (949) 548-2074
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Pelvic Floor questions:

Do you have pelvic pressure/ low back pain? No ☐ Yes ☐

Have you noticed tissue bulging from your vagina? No ☐ Yes ☐

Do you experience uncontrolled loss of urine? No ☐ Yes ☐

Causes of leakage: Cough ☐ Sneeze ☐ Exercise ☐

Other causes: _____

How often do you urinate during the day? Every_____hours

Number of times you get up at night to urinate? _____

Do you experience uncontrolled loss of stool? No ☐ Yes ☐

Are you sexually active? No ☐ Yes ☐

Is sex satisfying to you? No ☐ Yes ☐

Do you experience pain during or after intercourse? No ☐ Yes ☐

Medical History:

Cardiovascular	No ☐ Yes ☐	Heart attack ☐	High BP. ☐ High Cholesterol ☐
Respiratory	No ☐ Yes ☐	Asthma ☐	COPD ☐ Chronic cough ☐
Gastro-intestinal	No ☐ Yes ☐	Constipation ☐	Diarrhea ☐ IBS ☐ Hepatitis ☐
Urology	No ☐ Yes ☐	Kidney stones ☐	Recurrent Infections ☐
Endocrine	No ☐ Yes ☐	Diabetes ☐	Thyroid ☐ Weight changes ☐
Hematologic	No ☐ Yes ☐	Anemia ☐	Clotting / Bleeding problems ☐
Neurologic	No ☐ Yes ☐	Seizures ☐	Stroke ☐ Weakness ☐
Psychiatric	No ☐ Yes ☐	Depression ☐	Anxiety ☐ Bipolar Disorder ☐

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Surgical History: **Date:** **Reason for Surgery:**

Current Medications and dosages

Drug Allergies and type of reaction:

Social History:

What is your occupation? _____

Do you smoke?	No ☐	Yes ☐
Do you drink alcohol?	No ☐	Yes ☐
Do you exercise?	No ☐	Yes ☐

Family Medical History:

	Living (age/health)	Deceased (age/cause of death)
Mother		
Maternal Aunt(s)		
Father		
Sister(s)		
Brother(s)		

Do you have any other specific medical questions that you would like to discuss?

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