NHS Fife

UROGYNAECOLOGY NEW PATIENT PROFORMA

PATIENT ID LABEL

PLEASE FILL OUT THIS FORM AND BRING IT WITH YOU TO YOUR CLINIC APPOINTMENT

Date.....

TELL US ABOUT YOUR SYMPTOMS

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Urinary Symptoms

Do you leak when you cough, sneeze, laugh, move, walk or exercise? Yes/No
Do you have to rush to the toilet to pass urine? Yes/No
Would you leak if you are unable to get to the toilet on time? Yes/No
How often do you leak? .....
How long does it take before you need to pass urine gain?.....
How often do you need to pass urine during the night? .....
Does it hurt to pass urine? Yes/No
Do you suffer from recurrent urine infections? Yes/No
Have you noticed blood in your urine? Yes/No
Do you have any difficulty in passing urine? Yes/No
Does it take long to start passing urine? Yes/No
Does it come out in dribbles? Yes/No
Do you need to go back to complete emptying shortly after passing urine? Yes/No
Do you have times when you cannot pass urine, despite feeling you need to? Yes/No
Do you have to push with your finger into the front passage to help you pass urine? Yes/No
Do you use pads? Yes/No
What kind of pads do you use? Pantliners? Yes/No Proper pads Yes/No
How many do you use on average per day? .....

Prolapse Symptoms:

Do you feel any bulge or lump in the front passage? Yes/No
Do you see any bulge or lump in the front passage? Yes/No
Do you feel any dragging sensation? Yes/No
Do you feel discomfort on long standing or exertion Yes/No

Bowel Symtpoms:

How often do you open your bowel? .....

What was the motion like? .....

Do you take any medication to help emptying your bowel? Yes/No

Do you have to press with your hand to open your bowel? Yes/No

Do you feel you empty your bowel completely? Yes/No

If you have to go open your bowel, do you have to rush incase you pass a movement before you reach the toilet? Yes/No

Do you have accidents from the back passage? Yes/No

If so, is it wind? Yes/No Loose stool? Yes/No Solid stools? Yes/No

Sexual function symptoms:

Do you have regular sexual intercourse? Yes/No

If so, do you have any problems? Yes/No

If yes, is this because of your bladder/bowel/prolapse problem? Yes/No

Are you afraid of leaking urine during intercourse? Yes/No

Does the lump/bulge down below become in the way? Yes/No

Do you or your partner feel the front passage is not tight enough? Yes/No

Do you feel any pain with intercourse? Yes/No

Obstetric History:

How many deliveries have you had?

Normal ..... Ventouse ..... Forceps ..... Caesarean .....

Gynaecological History:

When was your last period? .....

Do you have any problems with your period? .....

When was your last smear? ..... What was the result?.....

Are you taking any contraception or hormone replacement therapy? Yes/No .....

Do you have any other gynaecological problems? .....

Past History:

Previous operations and their dates: .....

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Any medications currently being taken? .....

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Any allergies? .....

Any other medical conditions:

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Social History

Caffeine Yes/No Type .....

Fizzy Juice Yes/No

Smoker Yes/No How many? .....

Exercise

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Does your problem affect exercise? Yes/No

Do you take any recreational drugs? Ie Ketamine Yes/No

This document is a true likeness of the original

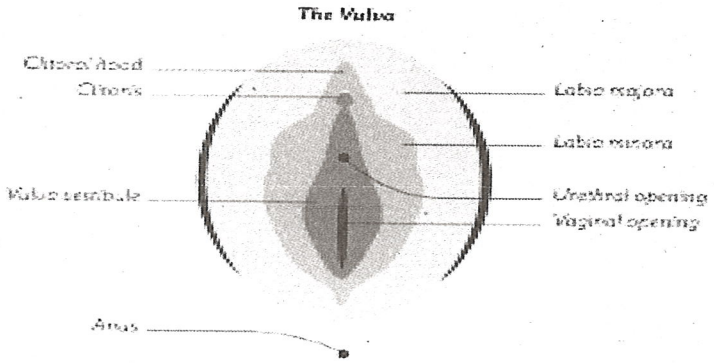
Print Name: M. Akhtar

Signature:

Date Stamp: KIRKBY B 18 FE 26 Post Office

TO BE COMPLETED BY A CLINICIAN

Examination Findings **Chaperone Req** **Yes/No**



Abdomen Exam

Vaginal mucosa ..... Healthy/Atrophic
...
Stress incontinence demonstrated Yes/No
Cervix visualized Yes/No
Bi-manual:

Urinalysis .....
Post void (if applicable) ..... mls

Pelvic Floor Muscle Assesment

Sensation.....Tenderness/Pain.....
Vaginal Size/Laxity.....Uterine Descent.....
Anterior Wall Prolapse.....Posterior Wall Prolapse.....

P	Performance (modified oxford grade)*		
E	Endurance (seconds held)		
R	Repetitions		
F	Fast Contractions		