LosAngeles Center for Women's Health

Darlene Morrissey, DO, FACOG
Female Pelvic Medicine and Reconstructive Surgery

Patient Name _____ Date: ___ /____ /____
Date of Birth: ___ /____ /____

Primary Care Physician: _____
Address: _____

Referring Physician: _____
Address: _____

How did you hear about us? (Please circle all that apply): Your doctor Friend Internet
Yellow Pages Newspaper Advertisement Other: _____

PAST MEDICAL HISTORY (Please circle all that apply):

High blood pressure:	Y N	Hyperthyroid:	Y N	COPD:	Y N
Heart Disease:	Y N	Hypothyroid:	Y N	Asthma:	Y N
Irregular Heart Beat:	Y N	Diabetes:	Y N	Glaucoma:	Y N
Pacemaker:	Y N	Liver Disease:	Y N	Depression:	Y N
Stroke/TIA:	Y N	Reflux:	Y N	Anxiety:	Y N
Kidney Failure:	Y N	Phlebitis/Clots:	Y N	Bipolar:	Y N
Kidney Stones:	Y N	Hemophilia:	Y N	MS:	Y N
Interstitial Cystitis:	Y N	Transfusion:	Y N	Vulvodynia:	Y N
Seasonal Allergies:	Y N	Fibromyalgia:	Y N	Arthritis:	Y N
IBS:	Y N				
Cancer:	Y N	Type of Cancer: _____			

Other history: _____

SURGERIES: (Please list any surgery you may have had and approximate date)

_____ _____
_____ _____
_____ _____

ALLERGIES: (Please list all allergies. If no allergies, please write "NONE")

_____

SOCIAL HISTORY: (Please circle all that apply)

Tobacco use:	Y N Quit	Alcohol use:	Y N Quit
Drug use:	Y N Quit	Domestic Violence:	Y N

FAMILY HISTORY: (Please circle Y or N and describe relative)

Diabetes:	N Y _____	Heart Disease:	N Y _____
Hypertension:	N Y _____	Stroke:	N Y _____
Breast Cancer:	N Y _____	Colon Cancer:	N Y _____

Other Family History: _____

PAST OBSTETRICAL/GYNECOLOGICAL HISTORY:

Was last PAP smear normal? Y N Date of last PAP smear _____
Was last mammogram normal? Y N Date of last mammogram _____

Deliveries:	Date	Vaginal/Cesarean/Forceps/Vacuum	Sex of Child	Weight

1513 S. Grand Avenue, Suite 400, Los Angeles, CA 90015 213.742.6400

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REVIEW OF SYSTEMS

Have you had any problems to the following systems in the past month? Circle Y or N

General
- Fatigue Y N
- Fever Y N
- Feel Ill Y N
- Night Sweats Y N
- Weight Gain Y N
- Weight Loss Y N

Ears, Nose, Throat
- Hearing loss Y N
- Runny nose Y N
- Ringing in ears Y N
- Sinus problems Y N
- Sore mouth Y N
- Sore throat Y N

Eyes
- Vision changes Y N

Skin
- Hair loss Y N
- Lesions Y N
- Rash Y N
- Worrisome mole Y N

Allergy/Immunologic
- Hay fever Y N
- HIV exposure Y N
- Hives Y N
- Persistent infections Y N

Breast
- Breast lump Y N

Respiratory
- Cough Y N
- Short of breath while lying down Y N
- Post-nasal drip Y N
- Short of breath Y N
- Wheezing Y N

Cardiovascular
- Chest pain Y N
- Leg pain with motion Y N
- Swelling in legs Y N
- Palpitations Y N
- Swelling elsewhere Y N

Endocrine
- Cold intolerance Y N
- Heat intolerance Y N
- Excessive thirst Y N
- Excess amount of urine Y N
- Night sweats Y N

Hematologic/Lymphatic
- Abnormal bruising Y N
- Excess bleeding Y N
- Swollen lymph glands Y N

Genitourinary
- Burning with urination Y N
- Urinary frequency Y N
- Blood in urine Y N
- Kidney stones Y N

Gynecologic
- Incontinence Y N
- Menstrual irregularity Y N
- Vaginal discharge Y N
- Vaginal dryness Y N
- Vaginal itching Y N
- Vaginal discomfort Y N
- Sexual dysfunction Y N

Gastrointestinal
- Abdominal pain Y N
- Constipation Y N
- Diarrhea Y N
- Difficulty swallowing Y N
- Blood in stool Y N
- Nausea Y N
- Vomiting Y N

Musculoskeletal
- Back pain Y N
- Neck pain Y N
- Joint pain Y N
- Stiffness Y N

Psychology
- Sleep problems Y N
- Depression Y N
- Anxiety Y N
- Suicidal thoughts Y N
- Hallucination Y N

Neurologic
- Headache Y N
- Weakness Y N
- Numbness Y N
- Memory loss Y N
- Tingling Y N
- Tremor Y N

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Name: _____Date of Birth: _____Today's Date _____

INCONTINENCE SEVERITY INDEX (ISI)

Please answer the following two (2) questions:

1. **How often do you experience urinary leakage?** (Please check one)

   _____ Never, I do not leak urine

   _____ Less than once a month

   _____ A few times a month

   _____ A few times a week

   _____ Every day and/or night

2. **How much urine do you lose each time?** (Please check one)

   _____ None, I do not leak urine

   _____ Drops

   _____ Small splashes

   _____ More

Thank you for answering these questions.

For office use only

ISI score _____

ISI category (circle):

None Slight (1-2) Moderate (3-6) Severe (8-9) Very severe (12)

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Three (3) Day Voiding Diary

Name____

Instructions:
1) Choose three days and keep track of how many times you void and when you leak
2) Every time that you void, place a "V" in the hour that corresponds to when you void
3) If you leak, place an "L" in the hour that corresponds to when you leak. If you leak more than once in any hour, place more "L's" below that hour
4) Each line represents a 24-hour period

Date ________________________

AM Noon PM Midnight

6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5

Date ________________________

AM Noon PM Midnight

6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5

Date ________________________

AM Noon PM Midnight

6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5

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