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

LosAngeles Center for Women's Health

Darlene Morrissey, DO, FACOG

Female Pelvic Medicine and Reconstructive Surgery

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

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

LosAngeles Center for Women's Health

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

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)

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

LosAngeles Center for Women's Health

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

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

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

LosAngeles Center for Women's Health

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

Pelvic Floor Impact Questionnaire

Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feelings. For each question place an **X** in the response that best describes how much your activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal symptoms or conditions **over the last 3 months**. Please make sure you mark an answer in **all 3 columns** for each question.

How do symptoms or conditions related to the following ➔ usually affect your ↓	Bladder or Urine	Bowel or Rectum	Vagina or Pelvis
1. Ability to do household chores (cooking, cleaning, etc.)?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
2. Ability to do physical activities, such as walking, swimming, or other exercise?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
3. Entertainment activities, such as going to a movie or concert?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
5. Participating in social activities outside your home?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
6. Emotional health (nervousness, depression, etc.)?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit
7. Feeling frustrated?	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit	□ Not at all □ Somewhat □ Moderately □ Quite a bit

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

LosAngeles Center for Women's Health

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

Pelvic Floor Distress Inventory Questionnaire

Instructions: 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 3 months**.

Patient Name_____

		If yes, how much does it bother you?			
		Not at all	**Somewhat**	**Moderately**	**Quite a bit**
1. Do you usually experience pressure in the lower abdomen?	YES ☐ NO ☐	☐	☐	☐	☐
2. Do you usually experience heaviness or dullness in the lower abdomen?	YES ☐ NO ☐	☐	☐	☐	☐
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	YES ☐ NO ☐	☐	☐	☐	☐
4. Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	YES ☐ NO ☐	☐	☐	☐	☐
5. Do you usually experience a feeling of incomplete bladder emptying?	YES ☐ NO ☐	☐	☐	☐	☐
6. Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	YES ☐ NO ☐	☐	☐	☐	☐
7. Do you feel you need to strain too hard to have a bowel movement?	YES ☐ NO ☐	☐	☐	☐	☐
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	YES ☐ NO ☐	☐	☐	☐	☐
9. Do you usually lose stool beyond your control if your stool is well-formed?	YES ☐ NO ☐	☐	☐	☐	☐

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

LosAngeles Center for Women's Health

Darlene Morrissey, DO, FACOG

Female Pelvic Medicine and Reconstructive Surgery

Patient Name_____

		If yes, how much does it bother you?			
		Not at all	**Somewhat**	**Moderately**	**Quite a bit**
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	YES □ NO □	□	□	□	□
11. Do you usually lose gas from the rectum beyond your control?	YES □ NO □	□	□	□	□
12. Do you usually have pain when you pass your stool?	YES □ NO □	□	□	□	□
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	YES □ NO □	□	□	□	□
14. Does part of your stool ever pass through the rectum and bulge outside during or after a bowel movement?	YES □ NO □	□	□	□	□
15. Do you usually experience frequent urination?	YES □ NO □	□	□	□	□
16. 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 □	□	□	□	□
17. Do you usually experience urine leakage related to laughing, coughing, or sneezing?	YES □ NO □	□	□	□	□
18. Do you usually experience small amounts of urine leakage (that is, drops)?	YES □ NO □	□	□	□	□
19. Do you usually experience difficulty emptying your bladder?	YES □ NO □	□	□	□	□
20. Do you usually experience pain of discomfort in the lower abdomen or genital region?	YES □ NO □	□	□	□	□

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