



**MetroHealth Medical Center**  
**DIVISION OF UROGYNECOLOGY &**  
**RECONSTRUCTIVE PELVIC SURGERY**  
**MINIMALLY INVASIVE SURGERY**

---

*PLEASE ANSWER EACH QUESTION TO THE BEST OF YOUR ABILITY. THIS INFORMATION IS IMPORTANT IN HELPING YOUR PHYSICIAN IN THE DIAGNOSIS AND TREATMENT OF YOUR GYNECOLOGIC PROBLEMS.*

---

**PLEASE ARRIVE AT YOUR APPOINTMENT WITH A FULL BLADDER.**

NAME: \_\_\_\_\_ Med. Rec #: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

**Patient History:**

Please describe the main reason you are seeing us today:

---

---

---

How many times have you been pregnant? \_\_\_\_\_

How many vaginal births have you had? \_\_\_\_\_

How many cesarean deliveries have you had? \_\_\_\_\_

When was your last pap smear? \_\_\_\_\_

Was is normal? \_\_\_\_\_

Do you have any problems with bladder control? \_\_\_\_\_

Do you have any problems with controlling your bowels? \_\_\_\_\_

Please list any other medical problems you may have, such as high blood pressure, diabetes, etc:

---

---

Please list the surgeries you have had and the approximate dates of each one:

---

---

---

---

Medications taken daily or regularly:

---

---

Please list any allergies:

---

---

Do you smoke? \_\_\_\_\_ Number of packs/cigarettes per day \_\_\_\_\_

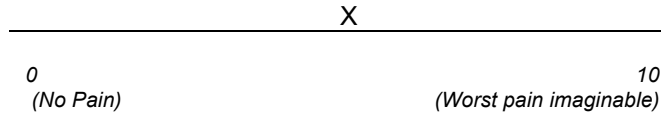
Did you ever smoke? \_\_\_\_\_ How many packs per day did you smoke? \_\_\_\_\_

When did you quit? \_\_\_\_\_

If you experience pain on a daily basis, please make an "X" on the line below to the corresponding level of your pain.

X

*For Example:*



**Your response:**

**10 Point Visual Pain Scale**

