Linda A. Kiley, MD

Linda Kiley, MD, Urogynecology
Advanced Pelvic Surgery

Original Date:
Dates Revised:

SUPPLEMENTAL QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*:		**DOB:**
☐ If you would like a report sent to your physician, check here	Name:	☐ Were you referred by another physician?
PREGNANCIES		
How many times have you been pregnant _____ Number of vaginal deliveries _____ Number of C-sections _____ Miscarriage/Abortions___		
Delivery complications (large tears, rectal trauma, bladder injuries)		
First day of last menstrual period:	Date of last rectal exam?	

UROGYNECOLOGIC SURGICAL HISTORY

Please check any surgeries you have had:				
Hysterectomy (circle one) Abdominal /Large Incision Vaginal Laparoscopic/Robotic				
☐ Operative hysteroscopy	☐ Exploratory surgery	☐ Myomectomy (laparosc)	☐ Urethral dilation/stretching	☐ Urethral bulking
☐ Botox in Bladder	☐ Interstim Implant	☐ Tubal ligation	☐ Fistula repair	☐ Hydrodistension (cysto)
☐ Radical surgery (cancer)	☐ Pelvic radiation (cancer)	☐ Ureter/bladder repair(circle)	☐ Cystocele repair	☐ Rectocele repair
Prolapse surgery (circle one) Abdominal /Large Incision Vaginal Laparoscopic/Robotic Was mesh used ? ☐ Yes ☐ No ☐ Not sure				
Incontinence surgery (circle one) Abdominal /Large Incision Vaginal: Synthetic mesh or Biologic Tissue sling? Laparoscopic/Robotic				
Repair of Rectal Prolapse (circle one) Abdominal /Large Incision Vaginal/transrectal Laparoscopic/Robotic Was any intestine removed ? ☐ Yes ☐ No				

Please add any other surgery not listed here
___If you have a medication sheet please check here and give a copy to the front desk

PLEASE COMPLETE NEXT PAGE OF QUESTIONNAIRE

Name *(Last, First, M.I.):*	**DOB:**

REVIEW OF SYSTEMS

Check any symptoms you currently have or have recently had:

☐ Fatigue	☐ Fever	☐ Unusual weight gain
☐ Visual problems	☐ Chills	☐ Unusual weight loss
☐ Eye pain	☐ Ringing in ears	☐ Hearing loss
☐ Nosebleeds	☐ Unusual or severe headaches	☐ Dizziness
☐ Sinus congestion or pain	☐ Persistent sore throat/pain swallowing	☐ Breast lumps
☐ Shortness of breath	☐ Mouth pain/sores	☐ Breast pain
☐ Cough or wheezing	☐ Chest pain with exertion	☐ Frequent palpitations
☐ Heartburn	☐ Diarrhea	☐ Nausea
☐ Changes in bowel habits	☐ Constipation	☐ Vomiting
☐ Accidental bowel leakage	☐ Frequent nighttime urination	☐ Blood in BM/tarry stools
☐ Involuntary loss of urine	☐ Strong frequent urges to urinate	☐ Difficulty urinating (starting or maintaining)
☐ Unusual vaginal discharge	☐ Blood in urine	☐ Burning or pain with urination
☐ Irregular vaginal bleeding	☐ Vaginal dryness	☐ Vaginal itching
☐ Painful intercourse	☐ Hot flashes	☐ Sexual difficulties/problems
☐ Bleeding after intercourse	☐ Night sweats	☐ Tissue protruding from the vagina
☐ Painful bowel movements	☐ Rash or itching	☐ Joint swelling
☐ Excessive thirst	☐ Changes in freckles or moles	☐ Joint pain
☐ Anxiety, excessive worry	☐ Thoughts of harming self/ others	☐ Muscle spasms
☐ Depression	☐ Memory difficulties	☐ Other pain/discomfort:
☐ Unsteadiness, loss of coordination	☐ Numbness/tingling in hands or feet	
☐ Bleeding tendency	☐ Easy bruising	