Date of office visit: _____

Your Name: _____

Your date of birth:_____ **Your** age:_____

How did you hear about Dr. Jayne? _____

Why are you seeing Dr. Jayne today? _____

Do you ever leak urine with **coughing sneezing** or **lifting** something? **Yes / No**

If **YES** how often? **Rarely / Sometimes / Often / Every time**

Do you ever have a sense of **urinary urgency**? **Yes / No** If **YES** how often? _____

If **YES**, do you ever **leak** urine with **urgency**? **Yes / No** If yes how often? _____

Do you ever have sense of **urinary frequency**? **Yes / No**
If **YES** how often do you urinate during the **day**? _____
How often do you get up at **night** to urinate? _____

Do you feel you **empty** your bladder to **completion** when you urinate? **Yes / No**
Do you ever have **pain** when you **urinate**? **Yes / No**
Do you ever have **pelvic pain** (* not related to urination)? **Yes / No**

Are you **sexually** active? **Yes / No**

If you are sexually active do you ever have **pain with sexual activity**? **Yes / No**

Do you ever have an **accidental** bowel movement or **leak** stool? **Yes / No**

Have you ever had **surgery** on your **bladder vagina** or **rectum**? **Yes / No**
If **YES** what year? _____

Have you had a **hysterectomy**? **Yes / No** If **YES** what year? _____
When was your last **pap smear**? _____
Have you ever had an **abnormal** pap smear? **Yes / No** If **yes** when? _____

When was your last **menstrual cycle**? _____
How many **vaginal deliveries** have you had? _____
How many **cesarean sections** have you had? _____