CENTER FOR SPECIAL MINIMALLY INVASIVE AND ROBOTIC SURGERY
Camran Nezhat Institute
900 Welch Road, Suite 403
Palo Alto, CA 94304
Phone (650) 327-8778
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Date Completed: ____/____/_____

# New Patient Assessment Form

*Contact Information*

Name: _____ Birth Date: ____/____/_____
Email: _____ SSN#: _____ - ____ - _____
Phone: Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____
Home Address: _____City:_____State: _____ Zip:_____
Referring Provider's Name and Address: _____
Emergency Contact and Phone Number: _____

Who is your primary care provider? _____
Address: _____ Phone #: (_____) _____-_____ Fax #: (_____) _____-_____
What pharmacy do you use? _____
Address: _____ Phone #: (_____) _____-_____ Fax #: (_____) _____-_____

*Basic Admission/Consultation Evaluation*

Age: _____ Height: _____ Weight: _____

Reason for Visit: □Endometriosis Evaluation □Pain Evaluation □Infertility Evaluation
□Other:_____

Please briefly describe your reason for visit:
_____
_____
_____

What questions do you want answered at this visit?
_____
_____
_____

What are your goals/expectations for your health/fertility/endometriosis treatment/for today's visit?
_____
_____
_____

*Demographic Information*

Are you (check all that apply)?
□Married □Widowed □Separated □Committed Relationship □Single □Divorced
What is your sexual preference (i.e. heterosexual, homosexual, bisexual, etc.)? _____
Whom do you live with? _____
Education: □Less than 12 years □High School Graduate □College Degree □Postgraduate Degree
What type of work are you doing? _____

## Medical and Surgical History

*Medical History:*

Allergies (Please list **ALL allergies**, including latex allergies, and the reactions you have):

_____
_____
_____

Please list any medical problems and diagnoses:

_____
_____
_____

Please list **all** surgical procedures you have had (use a separate page if needed):

| Year | Procedure | Surgeon | Findings |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

*For any surgeries related to the reason for your visit, please attach operative reports and pathology reports.*

Please list **all medications** (including herbs and supplements) you are presently taking, the condition, and the provider who prescribed them:

| Medication/dose | Provider | Medical Condition |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

*Menstrual History*

Age when you had your first period: _____ years old
Are you still having menstrual periods ? □Yes □No
If you are no longer having menstrual periods, at what age did you go through menopause? _____ years old
Have you had any vaginal bleeding after menopause? □Yes □No

*Answer the following only if you are still having menstrual periods:*

Menstrual cycle pattern (check all that apply):

□ Regular period's □ Spotting before periods □ Heavy periods □ Bleeding between periods
□ Irregular periods □ No periods □ Light periods

How many days of menstrual flow? _____ days
Number of days between the start of one period to the start of the next period: _____ days
Dates of the 1st day of your last 2 menstrual periods: _____/_____/_____; _____/_____/_____
Age when you first noticed: Breast development: ____years old | Pubic hair: ____years old | Underarm hair: ____years old
How many periods do you have per year? _____
Do you need medication to bring on a period, such as provera? □ No □ Yes - what type?
_____

Do you have severe cramping or pelvic pain with your periods?
□ No □ Yes: ____Always ____Sometimes ____ Recently ____In the past
Do you have pelvic pain with ovulation? □ No □ Yes
Do you have changes in bladder habits with your periods, such as bleeding or urgency? □ No □ Yes
If yes, please explain: _____
Do you have changes in bowel habits with your periods, such as constipation or diarrhea? □ No □ Yes
If yes, please explain: _____

Birth control method or Hormonal Medication:

□Nothing □Vaginal ring □IUD □Tubal Sterilization
□Pill □Depo provera □Hysterectomy □Other _____
□Vasectomy □Condom □Diaphragm

When was your last Pap smear? Date: ____/____/_____ Results: _____
Do you have a history of abnormal Pap? □ No □ Yes Result/Treatment: _____
Have you had the Gardasil vaccine? □No □Yes

When was your last mammogram? Date: ____/____/_____Results: _____
Do you have a history of abnormal mammogram? □ No □ Yes Result/Treatment: _____

Have you ever had an endometrial biopsy? □ No □ Yes Result/Treatment: _____
Have you ever had a colorectal screening? □ No □ Yes Result/Treatment: _____

| Have you ever had: | Yes | No | When | Result/Treatment |
|---|---|---|---|---|
| Chlamydia | | | | |
| Gonorrhea | | | | |
| Herpes | | | | |
| Trichomonas | | | | |
| Condyloma (warts) | | | | |
| Exposure to HIV | | | | |

## Pelvic Pain Assessment

Please describe your pain problem (use a separate sheet of paper if needed):

_____
_____
_____
_____
_____
_____

What do you think is causing your pain?_____
Is there an event that you associate with the onset of your pain? Yes No
If so, what?_____
How long have you had this pain? ____ years ____ months

*For each of the symptoms listed, place an **X** to indicate your level of pain over the last month using a 10 -point scale:*
0 - no pain 10 – the worst pain imaginable

| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| How would you rate your pain? | | | | | | | | | | | |
| Pain at ovulation (mid-cycle) | | | | | | | | | | | |
| Pain just before period | | | | | | | | | | | |
| Pain (not cramps) before period | | | | | | | | | | | |
| Deep pain with intercourse | | | | | | | | | | | |
| Pain in groin when lifting | | | | | | | | | | | |
| Pelvic pain lasting hours or days after intercourse | | | | | | | | | | | |
| Pain when bladder is full | | | | | | | | | | | |
| Muscle / joint pain | | | | | | | | | | | |
| Level of cramps with period | | | | | | | | | | | |
| Pain after period is over | | | | | | | | | | | |
| Burning vaginal pain after sex | | | | | | | | | | | |
| Pain with urination | | | | | | | | | | | |
| Backache | | | | | | | | | | | |
| Migraine headache | | | | | | | | | | | |
| Pain with sitting | | | | | | | | | | | |

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*Information About Your Pain*

What types of treatments / providers have you tried in the past for your pain? **Please check all that apply**

| | | | | | |
|---|---|---|---|---|---|
| □ | Acupuncture | □ | Family Practitioner | □ | Nutrition / diet |
| □ | Anesthesiologist | □ | Herbal Medicine | □ | Physical Therapy |
| □ | Anti-seizure medications | □ | Homeopathic medicine | □ | Psychotherapy |
| □ | Antidepressants | □ | Lupron, Synarel, Zoladex | □ | Psychiatrist |
| □ | Biofeedback | □ | Massage | □ | Rheumatologist |
| □ | Botox injection | □ | Meditation | □ | Skin magnets |
| □ | Contraceptive pills/patch/ring | □ | Narcotics | □ | Surgery |
| □ | Danazol (Danocrine) | □ | Naturopathic medication | □ | TENS units |
| □ | Depo-provera | □ | Nerve blocks | □ | Trigger point injections |
| □ | Gastroenterologist | □ | Neurosurgeon | □ | Urologist |
| □ | Gynecologist | □ | Nonprescription medicine | □ | Other:_____ |

Please comment on what has worked and has not worked for you in the past:

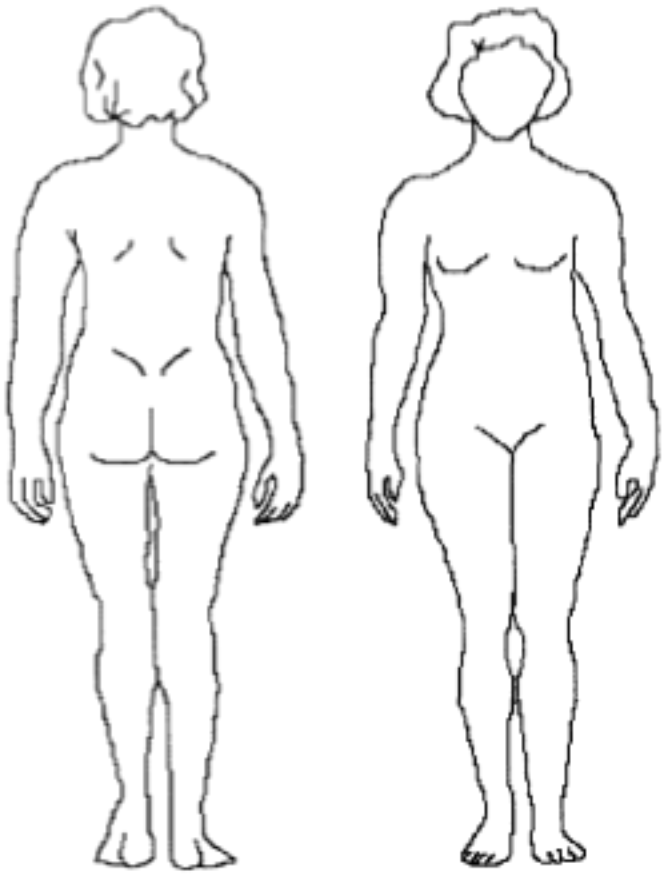
_____

_____

_____

*Pain Maps*

Please shade areas of pain and write a number from 1 to 10 at the site(s) of pain. (10 = most severe pain imaginable)



Left Right Right Left

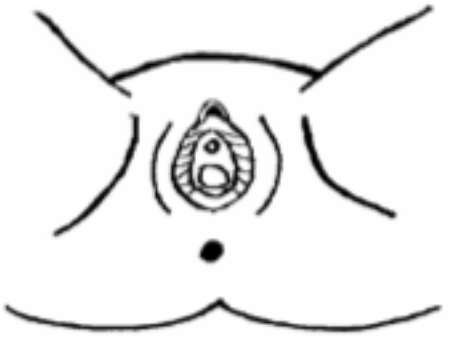
*Vulvar / Perineal Pain*
*(pain outside and around the vagina and anus)*

If you have vulvar pain, shade the painful areas and write a number from 1 to 10 at the painful sites. (10 = most severe pain imaginable)

Is your pain relieved by sitting on a commode seat?
Yes No

Right

Left



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*Short-Form McGill*

The words below describe average pain. Place a check mark ( √ ) in the column which represents the degree to which you feel that type of pain. Please limit yourself to a description of the pain in your pelvic area only .

What does your pain feel like?

| *Type* | *None (0)* | *Mild (1)* | *Moderate (2)* | *Severe (3)* |
|---|---|---|---|---|
| Throbbing | _____ | _____ | _____ | _____ |
| Shooting | _____ | _____ | _____ | _____ |
| Stabbing | _____ | _____ | _____ | _____ |
| Sharp | _____ | _____ | _____ | _____ |
| Cramping | _____ | _____ | _____ | _____ |
| Gnawing | _____ | _____ | _____ | _____ |
| Hot-Burning | _____ | _____ | _____ | _____ |
| Aching | _____ | _____ | _____ | _____ |
| Heavy | _____ | _____ | _____ | _____ |
| Tender | _____ | _____ | _____ | _____ |
| Splitting | _____ | _____ | _____ | _____ |
| Tiring-Exhausting | _____ | _____ | _____ | _____ |
| Sickening | _____ | _____ | _____ | _____ |
| Fearful | _____ | _____ | _____ | _____ |
| Punishing-Cruel | _____ | _____ | _____ | _____ |

*Melzak R. The Short-form McGill Pa in Questionnaire. Pain 1987;30:191-197.*

*Pelvic Varicosity Pain Syndrome Questions*

| | | |
|---|---|---|
| Is your pelvic pain aggravated by prolonged physical activity? | □Yes | □No |
| Does your pelvic pain improve when you lie down? | □Yes | □No |
| Do you have pain that is deep in the vagina or pelvis *during* sex? | □Yes | □No |
| Do you have pelvic throbbing or aching *after* sex? | □Yes | □No |
| Do you have pelvic pain that moves from side to side? | □Yes | □No |
| Do you have sudden episodes of severe pelvic pain that come and go? | □Yes | □No |

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## Infertility Assessment

*Fertility Questionnaire*

Do you plan on trying to get pregnant now or in the future? □ Yes □ No
Are you currently trying to get pregnant? □ Yes □ No
How long have you been trying? _____
Have you had any fertility treatment, such as IVF?
Does your partner have an abnormal semen analysis? □ Yes □ No
If yes, please explain: _____
Do you have any personal, ethical, or religious objections to any tests or treatments, such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc? □ Yes □ No
If yes, please explain:_____

*Fertility Treatment History*

Have you been treated for infertility previously? □ Yes □ No
If yes, where and when? _____

Which tests have been performed? (Please attach results of any tests)

□ Basal body temperature
□ Infection test (ureaplasma, mycoplasma)
□ Estradiol
□ Postcoital test
□ Endometrial biopsy
□ FSH
□ Clomid challenge test
□ Hysterosalpingogram
□ DHEAS
□ Sonohysterogram
□ Antibody tests
□ Thyroid tests
□ Testosterone
□ Ultrasound

Have you ever taken any of the following medications?

□ Clomid
□ Letrazole
□ HCG (Ovidrel)
□ Injectable Gonadotropins
□ Progesterone
□ Progestin
□ Estrogen
□ Testosterone

Have you ever attempted intrauterine insemination? □ Yes □ No
If yes, please list dates and semen donor (partner or anonymous):

_____
_____
_____
_____
_____

Have you ever attempted in vitro fertilization? □ Yes □ No
If yes, please list dates and results:

_____
_____
_____
_____
_____

Do you currently have any frozen embryos? □ Yes □ No
If yes, how many?

_____

*Obstetrical History*

How many pregnancies have you had? _____

Resulting in (#): Full 9 months ____ Premature ____ Miscarriage / Abortion ____ Living children ____

Number of Miscarriages (less than 20 weeks): _____

Number of Ectopic/Tubal Pregnancies: _____

Number of Elective Terminations/Abortions: _____

Were there any complications during pregnancy, labor, delivery, or postpartum?

□4° Episiotomy □Postpartum hemorrhaging □Medication for bleeding

□C-Section □Vaginal laceration □Other _____

□Vacuum □Forceps

Please list ALL of your pregnancies and their outcomes:

| Date | Treatments to Conceive | Delivery Type (Vaginal, Cesarean, D&C, etc) | Complications | Weight | Sex | Current Partner? |
|---|---|---|---|---|---|---|
| | | | | | □M □F | □Y □N |
| | | | | | □M □F | □Y □N |
| | | | | | □M □F | □Y □N |
| | | | | | □M □F | □Y □N |
| | | | | | □M □F | □Y □N |
| | | | | | □M □F | □Y □N |

*Gastrointestinal / Eating*

Do you have nausea? □No □With pain □Taking medications □With eating □Other

Do you have vomiting? □No □With pain □Taking medications □With eating □Other

Have you ever had an eating disorder such as anorexia or bulimia? □Yes □No

Are you experiencing rectal bleeding or blood in your stool? □Yes □No

Do you have increased pain with bowel movements? □Yes □No

*The following questions help to diagnose irritable bowel syndrome, a gastrointestinal condition, which may be a cause of pelvic pain.*

**Do you have pain or discomfort that is associated with the following:**

Change in frequency of bowel movement □Yes □No

Change in appearance of stool or bowel movement? □Yes □No

Does your pain improve after completing a bowel movement? □Yes □No

*Urinary Symptoms*

Do you experience any of the following?

| | | |
|---|---|---|
| Loss of urine when coughing, sneezing, or laughing? | □Yes | □No |
| Difficulty passing urine? | □Yes | □No |
| Frequent bladder infections? | □Yes | □No |
| Blood in the urine? | □Yes | □No |
| Still feeling full after urination? | □Yes | □No |
| Having to void again within minutes of voiding? | □Yes | □No |

*The following questions help to diagnose painful bladder syndrome, which may cause pelvic pain*

**Please circle the answer that best describes your bladder function and symptoms.**

| | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| 1. How many times do you go to the bathroom **DURING THE DAY** (to void or empty your bladder)? | 3-6 | 7-10 | 11-14 | 15-19 | 20 or more |
| 2. How many times do you go to the bathroom **AT NIGHT** (to void or empty your bladder)? | 0 | 1 | 2 | 3 | 4 or more |
| 3. If you get up at night to void or empty your bladder, does it bother you? | Never | Mildly | Moderately | Severely | |
| 4. Are you sexually active? □Yes □ No | | | | | |
| 5. If you are sexually acitve, do you now or have you ever have pain or symptoms during or after sexual intercourse? | Never | Occasionally | Usually | Always | |
| 6. If you have pain with intercourse, does it make you avoid sexual intercourse? | Never | Occasionally | Usually | Always | |
| 7. Do you have pain associated with your bladder or in your pelvis (lower abdomen, labia, vagina, urethra, perineum)? | Never | Occasionally | Usually | Always | |
| 8. Do you have urgency after voiding? | Never | Occasionally | Usually | Always | |
| 9. If you have pain, is it usually | Never | Mild | Moderate | Severe | |
| 10. Does your pain bother you? | Never | Occasionally | Usually | Always | |
| 11. If you have urgency, is it usually | | Mild | Moderate | Severe | |
| 12. Does your urgency bother you? | Never | Occasionally | Usually | Always | |

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*KCl ____ Not Indicated ____ Positive ____ Negative*

*Coping Mechanisms*

Who are the people you talk to concerning your pain, or during stressful times?

□Spouse / Partner □Clergy □Mental Health provider
□Relative □Doctor / Nurse □I take care of myself
□Support group □Friend

How does your partner deal with your pain?

□Doesn't notice when I'm in pain □Not applicable □Feels helpless
□Takes care of me □Withdraws □Distracts me with activities
□Gets angry

What helps your pain?

□Meditation □Massage □Pain medication □Bowel movement
□Relaxation □Ice □Laxatives / Enema □Emptying bladder
□Lying down □Heating pad □Injection □Nothing
□Music □Hot bath □TENS unit □Other _____

What makes your pain worse?

□Intercourse □Bowel movement □Walking □Contact with clothing
□Orgasm □Full bladder □Exercise □Coughing / sneezing
□Stress □Urination □Time of day □Not related to anything
□Full meal □Standing □Weather □Other _____

Of all the problems or stresses or your life, how does your pain compare in importance?

□The most important problem □Just one of many problems

*Sexual and Physical Abuse History*

Have you ever been the victim of emotional abuse? This can include being humiliated or insulted Yes No No answer

| As a child As an adult<br>Check an answer for both as a child and as an adult. | (13 and younger) | | (14 and over) | |
|---|---|---|---|---|
| 1a. Has anyone ever exposed the sex organs of their body to you when you did not want it? | Yes | No | Yes | No |
| 1b. Has anyone ever threatened to have sex with you when you did not want it? | Yes | No | Yes | No |
| 1c. Has anyone ever touched the sex organs of your body when you did not want this? | Yes | No | Yes | No |
| 1d. Has anyone ever made you touch the sex organs of their body when you did not want this? | Yes | No | Yes | No |
| 1e. Has anyone forced you to have sex when you did not want this? | Yes | No | Yes | No |
| 1f. Have you had any other unwanted sexual experiences not mentioned above? | Yes | No | Yes | No |

If yes, please specify _____

2. When you were a child (13 or younger), did an older person do the following?

a. Hit, kick, or beat you? Never Seldom Occasionally Often
b. Seriously threaten your life? Never Seldom Occasionally Often

3. Now that you are an adult (14 or older), has any other adult done the following?

a. Hit, kick, or beat you? Never Seldom Occasionally Often
b. Seriously threaten your life? Never Seldom Occasionally Often

*Leserman, J, Drossman D, Li Z. The reliability and validity of a sexual and physical abuse history questionnaire in female patients with gastrointestinal disorders. Behavioral Medicine 1995;21:141-148.*

*Family History*

Please list all family members with diagnoses such as fibromyalgia, chronic pelvic pain, irritable bowel syndrome, depression, interstitial cystitis, endometriosis, cancer, and any other chronic conditions:

| Family Member | Condition |
|---|---|
| | |
| | |
| | |
| | |

*Health Habits*

How often do you exercise? □Rarely □1-2 times weekly □3-5 times weekly □Daily

What is your caffeine intake (number cups per day, include coffee, tea, soft drinks, etc)? □0 □1-3 □4-6 □>6

How many cigarettes do you smoke per day? _____ For how many years? _____

Do you drink alcohol? □Yes □No Number of drinks per week _____

Have you ever received treatment for substance abuse? □Yes □No

What is your use of recreational drugs?

□Never used
□Used in the past, but not now
□Presently using
□No answer

□Heroin □Marijuana □Cocaine
□Amphetamines □Barbiturates □Other _____

How would you describe your diet? (check all that apply)

□Well balanced □Vegan □Vegetarian □Fried food
Special diet _____ Other _____

Have you ever been hospitalized for anything other than childbirth? □Yes □No

If yes, please explain: _____

Have you had major accidents such as falls or a back injury? □Yes □No

Have you ever been treated for depression? □Yes □No

Treatments: □Medication □Hospitalization □Psychotherapy

*Provider Comments*

_____

_____

_____

_____

_____

Patient history reviewed by Dr. _____

Date: _____