

# New Patient/Annual FEMALE GENITOURINARY EXAM

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

What is the main reason for your visit today? Describe your problem in detail \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS AS COMPLETELY/AS POSSIBLE**

• WHERE is your problem?  
 Abdomen / Back / Genitals / Other  
 Describe: \_\_\_\_\_



• Do you have any PAIN?  
 YES NO (If "NO" skip the next question)

• What KIND of pain do you have? Sharp / Dull / Throbbing / Achy /  
 Pressure / Cramping / Crushing / Vague  
 Describe: \_\_\_\_\_

• On a scale of 1-10, (10 is the most severe) circle the number that  
 best describes the SEVERITY of your problem or your pain.  
 (No problem) 1 2 3 4 5 6 7 8 9 10 (most severe)

• When did you FIRST NOTICE the problem? (When did it start?)  
 How many (circle one) days / weeks / months ago: \_\_\_\_\_

• HOW LONG does each episode last?  
 Seconds / Minutes / Hours / Days / Always there  
 Describe: \_\_\_\_\_

• WHEN does this problem happen?  
 Daytime / Nighttime / When you are active / Unpredictable  
 Describe: \_\_\_\_\_

• HOW OFTEN are you having the problem or the pain?  
 Describe: \_\_\_\_\_

• What HELPS or what makes the problem WORSE?  
 Describe: \_\_\_\_\_

• Are any OTHER SYMPTOMS occurring at the same time?  
 Describe: \_\_\_\_\_

• List all of your current health conditions, and list all  
 hospitalizations and surgeries you have had:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

• List all medications you take regularly:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

• List all medication allergies:  
 \_\_\_\_\_  
 \_\_\_\_\_

• Do you smoke? No Yes How Much?  
 \_\_\_\_\_

• Do you use drugs or alcohol? No Yes How Much?  
 \_\_\_\_\_

• What is/was your occupation? (What did you retire from?)  
 \_\_\_\_\_

• What is your current marital status?  
 Single / Married / Separated / Divorced / Widowed

• List all serious illnesses in your family, including parents, grand-  
 parents and siblings. (Diabetes, any kind of cancer, high blood  
 pressure, heart disease, kidney disease or stones, thyroid disease, etc.)

Mother: \_\_\_\_\_  
 Maternal GM: \_\_\_\_\_  
 Maternal GP: \_\_\_\_\_  
 Father: \_\_\_\_\_  
 Paternal GM: \_\_\_\_\_  
 Paternal GP: \_\_\_\_\_  
 Bro./Sis.: \_\_\_\_\_

• Do you have any of the following problems TODAY? Please mark YES (Y) or NO (N) for EACH item below.

Y N Kidney disease	Y N Fever	Y N Wheezing	Y N Back pain	Y N Easy bruising
Y N Bloody urine	Y N Chills	Y N Frequent cough	Y N Headaches	Y N Seasonal allergies
Y N Painful urination	Y N Change in Weight	Y N Short of breath	Y N Tremors	Y N Other health problems
Y N Urinary hesitancy	Y N Change in appetite	Y N Abdominal pain	Y N Numbness or tingling	
Y N Urinary retention	Y N Blurred/double vision	Y N Nausea	Y N Dizzy Spells	
Y N Urinary frequency	Y N Eye pain	Y N Vomiting	Y N Anxiety	
Y N Urinary urgency	Y N GI pain	Y N Indigestion	Y N Depression	
Y N Urinary incontinence	Y N Hearing loss	Y N Heartburn	Y N Insomnia	
Y N Nighttime urinations	Y N Snot problems	Y N Skin problems	Y N Excessive thirst	
How many? _____	Y N Sore throat	Y N Skin cancer	Y N Intolerant to heat/cold	
GATE last period Started?	Y N Chest pain	Y N Joint pain	Y N Tired or fatigued	
	Y N Vaginal w/wh	Y N Neck pain	Y N Swollen Glands	

Physician / provider use only (initials/signature): \_\_\_\_\_

Time in: \_\_\_\_\_