New Patient/Annual FEMALE GENITOURINARY EXAM

Patient Name: _____ DOB: _____ Date of Visit: _____

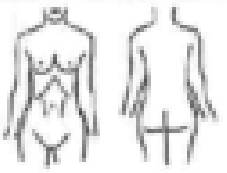
What is the main reason for your visit today? Describe your problem in detail _____

_____

_____

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 / Seperated / Divorced / Widowed
- **List all serious illnesses in your family, including parents, grandparents and siblings. (Diabetes, any kind of cancer, high blood pressure, heart disease, kidney disease or stones, thyroid disease, etc.)**

Mother: _____
Maternal GM: _____
Maternal GF: _____
Father: _____
Paternal GM: _____
Paternal GF: _____
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 Ear 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 Sinus 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	
DATE last period Started?	Y N Chest pain	Y N Joint pain	Y N Tired or fatigued	
_____	Y N Varicose veins	Y N Neck pain	Y N Swollen Glands	

Physician / provider use only (notes/comments):

Time In: