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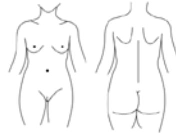
NEW PATIENT/ANNUAL FEMALE GENITOURINARY EXAM

Patient Name: ______________________ Age: ____________ 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/month(s) 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 occuring 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 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, 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: ______________________
Brothers/Sisters: ______________________

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 Bloody Urine	Y N Chills	Y N Frequent Cough	Y N Headaches
Y N Painful Urination	Y N Change in Weight	Y N Short of Breath	Y N Tremors
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 Vision	Y N Double Vision	Y N Nausea
Y N Urinary Frequency	Y N Eye Pain	Y N Vomiting	Y N Anxiety
Y N Urinary Incontinence	Y N Ear Pain	Y N Heartburn	Y N Excessive Thirst
Y N Urinary Urgency	Y N Sinus problems	Y N Skin problems	Y N Insomnia
Y N Nighttime Urinations	Y N Sore Throat	Y N Skin Cancer	Y N Dizzy Spells
DATE last period started?	Y N Chest Pain	Y N Joint Pain	Y N Tired or Fatigued
Y N Hearing Loss	Y N Varicose Veins	Y N Neck Pain	Y N Swollen Glands
	Y N Intolerant to Heat/Cold	Y N Seasonal Allergies	Y N Easy Bruising

Physician/Provider use only (Notes/Comments)

Time in: