# FEMALE PATIENT HISTORY FORM

**PATIENT'S NAME:**__________________________ DATE OF BIRTH:_____________________ AGE:________

PRIMARY CARE PHYSICIAN (FAMILY DOCTOR)______________________________________________

**CHIEF COMPLAINT** (What is the main reason for your visit to the urologist today? How long have you been having this problem?______________________________________________

______________________________________________

## HISTORY OF PRESENT ILLNESS

**Do you have or have you recently had any of the following listed below? Please circle your responses.**

- Blood in your urine?........ YES NO
- Weak, dribbling stream or trouble starting your urine (poor force)........ YES NO
- Awaken frequently at night to urinate? If yes, how often?........ YES NO
- Burning or pain when you urinate?........ YES NO
- Back pains?........ YES NO
- Leakage of urine when coughing, straining, sneezing or exercising?........ YES NO
- Leakage of urine when getting up from a chair?........ YES NO
- Leakage of urine if you don't get to the bathroom immediately?........ YES NO
- Urinating more frequently than usual? If yes, how often?........ YES NO
- Discharge from the vagina?........ YES NO
- Kidney or bladder stones?........ YES NO
- Urinary tract infections?........ YES NO
- Bedwetting or daytime wetting of clothes?........ YES NO
- History of a sexually transmitted disease (herpes, gonorrhea, chlamydia, etc.)........ YES NO
- Pain with sexual intercourse?........ YES NO
- Fertility problems?........ YES NO
- Have you ever had kidney x-rays (IVP or ultrasound) performed?........ YES NO
- Are you currently pregnant or are you actively trying to become pregnant?........ YES NO

## OB/GYN HISTORY

How many times have you been pregnant? ________

How many vaginal deliveries?________

How many C-section deliveries? ________

Date of your last period?________

Date of your last Pap smear? ________

Have you had a hysterectomy?_____ Yes _____ No

What method do you use to prevent pregnancy?

______________________________________________

Physician Use Only

## PAST MEDICAL AND SURGICAL HISTORY

Serious Medical Illnesses (Check all that apply)

____ Heart problems? ____ Thyroid problems ____ Cancer ____ Arthritis

____ Lung (breathing) problems ____ Kidney disease ____ Neurological problems ____ Bleeding problems

____ High blood pressure ____ Ulcers ____ Diabetes

Previous Major Surgeries (Please list)

| Date | Type | Surgeon | Hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Other Surgeries or Previous Hospitalizations (Please list)

| Date | Reason | Physician/Surgeon | Hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## MEDICATIONS

Please list all prescription and over-the-counter medications, including vitamins and herbs that you are taking.

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

Do you use any nitroglycerin medications (medicine for chest pain?) ____ Yes ____ No

## ALLERGIES TO MEDICATIONS

____________________ ____________________

____________________ ____________________

______ NKDA

Have you had a reaction to iodine x-ray dye? ___ Yes ___No

If yes, what type of reaction? ____________________________

Are you allergic to shellfish?___Yes ___ No

## SOCIAL HISTORY

______ Married ______ Single ______Widowed ______ Separated ______ Divorced

How many children do you have? _________ Occupation: ______________________________________________

Do you currently smoke?______Yes ______ No If yes, how many packs per day? ______________________

If no, have you ever smoked? _____Yes ______ No

Do you drink alcohol? ______Yes ______ No If yes, how often? ___________________________________

## FAMILY HISTORY (check all that apply)

_____ Heart disease

_____ Lung disease

_____ High blood pressure

_____ Strokes

_____ Prostate disease

_____ Kidney disease or stones

_____ Diabetes

_____ Arthritis

_____ Cancer

_____ Tuberculosis

_____ Neurological problems

Physician use only

PATIENT'S NAME:______________________________ DATE OF BIRTH: __________________

## REVIEW OF SYSTEMS

Do you currently have any problems related to the areas outlined below? Please circle all that apply.

- **GENERAL**
  Weight change  Loss of appetite  Night sweats  Fatigue  Nausea  Fever  Chills

__ *Negative review*

- **HEAD/EYES/EARS/NOSE/THROAT**
  Headaches/Migraines  Hearing problems  Ringing in ears  Nasal congestion  Eye pain
  Dental problems  Dry mouth  Difficulty swallowing  Vision problems/Glaucoma  Sore throat

__ *Negative review*

- **RESPIRATORY**
  Cough  Phlegm  Bloody phlegm  Shortness of breath

__ *Negative review*

- **CARDIOVASCULAR**
  Chest pain  Irregular heart beat  Leg cramps  Easy bruising  Varicose veins

__ *Negative review*

- **GASTROINTESTINAL**
  Pain with swallowing  Stomach pain  Vomiting  Bloody stools  Black stools
  Constipation  Diarrhea

__ *Negative review*

- **NEUROLOGICAL**
  Numbness  Tremor  Double-vision  Balance problems  Poor memory

__ *Negative review*

- **MUSCULOSKELETAL**
  Weakness  Difficulty walking  Bone or join pains  Loss of muscle mass

__ *Negative review*

- **ENDOCRINE**
  Excessive thirst  Temperature intolerance  Breast pain or lump  Nipple discharge
  Decreased libido

__ *Negative review*

- **SKIN**
  Change in skin or nail texture  Itchy skin  Hives  Dry skin  Hair loss

__ *Negative review*