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*