

Health History – FEMALE

REASON FOR YOUR VISIT		
PRIOR EVALUATION BY UROLOGIST? (when, reason, and by whom)		
MEDICAL HISTORY (Please check all that apply and note how long the problem has existed)		
<input type="checkbox"/> Abnormal heart rhythm / Atrial fibrillation	<input type="checkbox"/> Esophageal reflux	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Anemia (Low blood count)	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gout	<input type="checkbox"/> Sexually transmitted disease: _____
<input type="checkbox"/> Asthma / emphysema / COPD	<input type="checkbox"/> Heart attack / coronary artery disease	<input type="checkbox"/> Stroke / TIA
<input type="checkbox"/> Autoimmune or connective tissue	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Bleeding / clotting disorders	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood clots in the legs or lungs	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Peptic ulcer disease
<input type="checkbox"/> Cancer: _____	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Urinary tract infections
<input type="checkbox"/> Colitis or inflammatory bowel disease	<input type="checkbox"/> HIV infection / AIDS	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Depression or anxiety	<input type="checkbox"/> Infertility	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney disease / Renal failure	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diverticulosis or Diverticulitis	<input type="checkbox"/> Kidney stones / Bladder stones	<input type="checkbox"/> Other: _____
SURGICAL HISTORY (Please check all that apply and circle the specific associated procedures. Pls include dates if possible)		
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Gallbladder removal: open vs laparoscop	<input type="checkbox"/> Pacemaker placement
<input type="checkbox"/> Bladder tumor removal (Transurethral)	<input type="checkbox"/> Hernia repair: _____	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Bladder removal (Total Cystectomy)	<input type="checkbox"/> Hysterectomy: open / vaginal / laparoscop	<input type="checkbox"/> Tubal ligation
<input type="checkbox"/> Breast surgery	<input type="checkbox"/> Joint surgery: _____	<input type="checkbox"/> Vaginal prolapse repair
<input type="checkbox"/> Caesarian section: how many? _____	<input type="checkbox"/> Urine leakage surgery: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Coronary stent or bypass (CABG)	<input type="checkbox"/> Kidney stone surgery: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Colon surgery (Colectomy)	<input type="checkbox"/> Kidney surgery: total or partial removal	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Eye surgery: _____	<input type="checkbox"/> Ovary removal: LT RT BL	<input type="checkbox"/> Other: _____
FAMILY HISTORY Please note relation (parent, sibling, or offspring)		
<input type="checkbox"/> Abnormal bleeding/bruising: _____	<input type="checkbox"/> Breast cancer: _____	<input type="checkbox"/> Kidney cancer: _____
<input type="checkbox"/> Genetic diseases: _____	<input type="checkbox"/> Ovarian cancer: _____	<input type="checkbox"/> Problems with anesthesia: _____
<input type="checkbox"/> Kidney stones: _____	<input type="checkbox"/> Uterine cancer: _____	<input type="checkbox"/> Other: _____

SOCIAL HISTORY / HEALTH HABITS			
Marital Status Single Mar Wid Div Sep		Whom do you live with?	Are you currently sexually active?
SMOKING STATUS		<input type="checkbox"/> Current	<input type="checkbox"/> Former <input type="checkbox"/> Never a Smoker
		<input type="checkbox"/> _____ packs/day	<input type="checkbox"/> How many years? _____ <input type="checkbox"/> Quit _____ yrs ago
ALCOHOL USE : <input type="checkbox"/> No <input type="checkbox"/> Yes: How many drinks / wk?		CAFFEINE USE : <input type="checkbox"/> No <input type="checkbox"/> Yes: How many drinks / day?	
CURRENT OR FORMER OCCUPATION:			

OBSTETRIC HISTORY	Total # of Pregnancies: _____	# of Live Births: _____	Wt of Largest Baby: _____
# of Vaginal Delivery: _____ # of C-section: _____ # of Abortions: _____			
Any delivery complications? Please describe:			
GYNECOLOGICAL HISTORY	Date of Last Period: _____	Date of Last Pap: _____	Using birth control?
Are you in menopause? <input type="checkbox"/> No <input type="checkbox"/> Yes: When? _____		Are you on hormonal therapy? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____	

REVIEW OF SYSTEMS Please check any symptoms that you have had in the last 6 months

URINARY			
<input type="checkbox"/> Frequency: how many times during the day do you urinate? _____		<input type="checkbox"/> Straining to void	<input type="checkbox"/> Urethral discharge
<input type="checkbox"/> Urgency: if yes, do you ever leak related to a strong urge? _____		<input type="checkbox"/> Intermittent stream	<input type="checkbox"/> Blood in the urine
<input type="checkbox"/> Nocturia: how many times at night do you wake to urinate? _____		<input type="checkbox"/> Slow / decreased stream	<input type="checkbox"/> Burning with urination
<input type="checkbox"/> Leakage of urine with straining, coughing, exercise? _____		<input type="checkbox"/> Incomplete bladder emptying	<input type="checkbox"/> Pelvic pain
<input type="checkbox"/> Pads for urine leakage? If yes, how many per day? _____		<input type="checkbox"/> Pain with full bladder	<input type="checkbox"/> Flank / Kidney pain
GENERAL	RESPIRATORY	MUSCULOSKELETAL	PSYCHOSOCIAL
<input type="checkbox"/> Fevers	<input type="checkbox"/> Cough	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Depression
<input type="checkbox"/> Chills	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Back pain	<input type="checkbox"/> Difficulty concentrating
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Bone pain	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Poor appetite	GASTROINTESTINAL	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Difficulty sleeping
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Excessively high stress
EENT	<input type="checkbox"/> Nausea / Vomiting	SKIN / BREAST	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Constipation	<input type="checkbox"/> Loss or growth of hair	<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Breast lumps	LYMPHATIC / ENDOCRINE
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Lymph node tenderness
<input type="checkbox"/> Recent vision changes	<input type="checkbox"/> Changes in bowel habits	<input type="checkbox"/> Breast swelling	<input type="checkbox"/> Swollen glands
CARDIOVASCULAR	<input type="checkbox"/> Blood in the stools	<input type="checkbox"/> Nipple discharge	<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Racing heart or palpitations	<input type="checkbox"/> Stool incontinence	NEUROLOGICAL	<input type="checkbox"/> Intolerance to hot / cold
<input type="checkbox"/> Chest pain	GYNECOLOGIC	<input type="checkbox"/> Tremor	<input type="checkbox"/> Lack of energy or strength
<input type="checkbox"/> Calf pain with exercise	<input type="checkbox"/> Irregular or heavy periods	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Swelling of legs	<input type="checkbox"/> Bleeding since menopause	<input type="checkbox"/> Numbness in body part	
Can you walk > 2 blocks or 2 flights without shortness of breath? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Headaches	
	<input type="checkbox"/> Painful intercourse	<input type="checkbox"/> Incoordination	
	<input type="checkbox"/> Vaginal itching or discomfort	<input type="checkbox"/> Tingling / Pins and needles	
	<input type="checkbox"/> Vaginal bulge / falling organs	<input type="checkbox"/> Paralysis	

