# 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)

- [ ] Abnormal heart rhythm / Atrial fibrillation
- [ ] Anemia (Low blood count)
- [ ] Arthritis
- [ ] Asthma / emphysema / COPD
- [ ] Autoimmune or connective tissue disorder
- [ ] Bleeding / clotting disorders
- [ ] Blood clots in the legs or lungs
- [ ] Cancer:
- [ ] Colitis or inflammatory bowel disease
- [ ] Depression or anxiety
- [ ] Diabetes
- [ ] Diverticulosis or Diverticulitis
- [ ] Esophageal reflux
- [ ] Glaucoma
- [ ] Gout
- [ ] Heart attack / coronary artery disease
- [ ] Heart failure
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Kidney disease / Renal failure
- [ ] Kidney stones / Bladder stones
- [ ] Hepatitis
- [ ] HIV infection / AIDS
- [ ] Infertility
- [ ] Kidney disease
- [ ] Multiple sclerosis
- [ ] Parkinson's Disease
- [ ] Sexually transmitted disease:
- [ ] Stroke / TIA
- [ ] Thyroid disease
- [ ] Tuberculosis
- [ ] Urinary tract infections
- [ ] Other:

## SURGICAL HISTORY  (Please check all that apply and circle the specific associated procedures. Pls include dates if possible)

- [ ] Appendectomy
- [ ] Bladder tumor removal (Transurethral)
- [ ] Bladder removal (Total Cystectomy)
- [ ] Breast surgery
- [ ] Caesarian section: how many?
- [ ] Coronary stent or bypass (CABG)
- [ ] Colon surgery (Colectomy)
- [ ] Eye surgery: Collectomy
- [ ] Gallbladder removal: open vs laparoscopic
- [ ] Hernia repair:       
- [ ] Hysterectomy: open / vaginal / laparoscopic
- [ ] Joint surgery:       
- [ ] Kidney disease
- [ ] Kidney stone surgery:       
- [ ] Kidney surgery: total or partial removal
- [ ] Ovary removal: LT  RT  BL
- [ ] Pacemaker placement
- [ ] Tonsillectomy
- [ ] Tubal ligation
- [ ] Vaginal prolapse repair
- [ ] Vaginal ligation
- [ ] Urine leakage surgery:
- [ ] Other:

## FAMILY HISTORY  Please note relation (parent, sibling, or offspring)

- [ ] Abnormal bleeding/bruising:
- [ ] Breast cancer:
- [ ] Genetic diseases:
- [ ] Kidney stones:
- [ ] Kidney cancer:
- [ ] Ovarian cancer:
- [ ] Problems with anesthesia:
- [ ] Renal failure:
- [ ] Ultrasound:       
- [ ] Other:
### SOCIAL HISTORY / HEALTH HABITS

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Whom do you live with?</th>
<th>Are you currently sexually active?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single, Mar, Wid, Div, Sep</td>
<td>□ Current</td>
<td>□ Former</td>
</tr>
<tr>
<td>□ Never a Smoker</td>
<td>□ How many packs/day</td>
<td>□ How many years?</td>
</tr>
<tr>
<td>□ Quit ___ yrs ago</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SMOKING STATUS</th>
<th>□ No</th>
<th>□ Yes: How many drinks / wk?</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALCOHOL USE</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CAFFEINE USE</th>
<th>□ No</th>
<th>□ Yes: How many drinks / day?</th>
</tr>
</thead>
</table>

### OBSTETRIC HISTORY

<table>
<thead>
<tr>
<th>Total # of Pregnancies:</th>
<th># of Live Births:</th>
<th>Wt of Largest Baby:</th>
</tr>
</thead>
</table>

| # of Vaginal Delivery: | # of C-section: | # of Abortions: |

Any delivery complications? Please describe:

### GYNECOLOGICAL HISTORY

<table>
<thead>
<tr>
<th>Date of Last Period:</th>
<th>Date of Last Pap:</th>
<th>Using birth control?</th>
</tr>
</thead>
</table>

Are you in menopause? □ No □ Yes: When? □ Yes: Are you on hormonal therapy? □ No □ Yes:

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

#### URINARY

- □ Frequency: how many times during the day do you urinate? ___
- □ Urgency: if yes, do you ever leak related to a strong urge? ___
- □ Nocturia: how many times at night do you wake to urinate? ___
- □ Leakage of urine with straining, coughing, exercise? ___
- □ Pads for urine leakage? If yes, how many per day? ___

#### GENERAL

- □ Fevers
- □ Chills
- □ Weight loss
- □ Poor appetite
- □ Fatigue

#### RESPIRATORY

- □ Cough
- □ Shortness of breath
- □ Wheezing

#### GASTROINTESTINAL

- □ Abdominal pain
- □ Nausea / Vomiting
- □ Constipation
- □ Diarrhea
- □ Heartburn
- □ Changes in bowel habits
- □ Blood in the stools
- □ Stool incontinence

#### MUSCULOSKELETAL

- □ Joint pain
- □ Back pain
- □ Bone pain
- □ Muscle pain
- □ Sciatica

#### SKIN / BREAST

- □ Loss or growth of hair
- □ Breast lumps
- □ Breast tenderness
- □ Breast swelling
- □ Nipple discharge

#### NEUROLOGICAL

- □ Tremor
- □ Dizziness
- □ Numbness in body part
- □ Headaches
- □ Incoordination
- □ Paralysis

#### NEUROLOGICAL

- □ Intolerance to hot / cold
- □ Excessive thirst

#### Lymphatic / Endocrine

- □ Lymph node tenderness
- □ Swollen glands
- □ Excessive thirst

#### Psychosocial

- □ Depression
- □ Difficulty concentrating
- □ Anxiety
- □ Difficulty sleeping
- □ Excessively high stress
- □ Memory problems
- □ Psychiatric care

#### Systemic

- □ Hot flashes
<table>
<thead>
<tr>
<th>ANY KNOWN DRUG ALLERGIES?</th>
<th>If so, please list drug and type of reaction it caused (rash, swelling, difficulty breathing, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>ANY ALLERGY TO LATEX (RUBBER PRODUCTS)?</td>
<td>□ No  □ Yes - Describe: ___________________________________________________________________</td>
</tr>
<tr>
<td>ANY ALLERGY TO SHELLFISH OR “IODINE DYE” (for X-ray studies)?</td>
<td>□ No  □ Yes - Describe: ___________________________________________________________________</td>
</tr>
<tr>
<td>CURRENT MEDICATIONS</td>
<td>Please include prescriptions, vitamins, supplements, and over-the-counter medication □ NONE</td>
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