

**Patient Medical History-Female**  
**Victoria Urological Associates, PA**

Date: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_ **Primary Care Doctor:** \_\_\_\_\_

**CHIEF COMPLAINT** (Reason for visit): \_\_\_\_\_

**UROLOGIC HISTORY** (Check all that apply):

A. Urinary Symptoms

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Urgent need to urinate?
<input type="checkbox"/>	<input type="checkbox"/>	Frequently need to urinate? If so, how often? _____
<input type="checkbox"/>	<input type="checkbox"/>	Strain to void
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty starting your urine stream
<input type="checkbox"/>	<input type="checkbox"/>	Need to void at night, if so how often? _____
<input type="checkbox"/>	<input type="checkbox"/>	Pain with urination
<input type="checkbox"/>	<input type="checkbox"/>	Pain/Pressure in lower abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Incomplete emptying of your bladder
<input type="checkbox"/>	<input type="checkbox"/>	Dribbling of urine after voiding
<input type="checkbox"/>	<input type="checkbox"/>	Blood in your urine
<input type="checkbox"/>	<input type="checkbox"/>	History of urinary infections. If so, how many in the past year? _____
<input type="checkbox"/>	<input type="checkbox"/>	Diagnosis of interstitial cystitis

B. Urinary Incontinence

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever experienced urinary incontinence? If so, for how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever experienced urinary incontinence due to activities such as coughing, laughing, sneezing, or exercise?
<input type="checkbox"/>	<input type="checkbox"/>	Do you sometimes have trouble getting to the bathroom in time to void?
<input type="checkbox"/>	<input type="checkbox"/>	Do you unexpectedly loose control of your urine?
		If so, is it caused by:
		<input type="checkbox"/> Sight, sound or feel of running water
		<input type="checkbox"/> "Key in the door" when returning home
		<input type="checkbox"/> Standing up after being seated
		<input type="checkbox"/> Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you wet the bed while sleeping?
<input type="checkbox"/>	<input type="checkbox"/>	Do you loose urine during intercourse?
<input type="checkbox"/>	<input type="checkbox"/>	Do you use protective pads for incontinence?
		How <u>many</u> , per day _____ and per night _____.
<input type="checkbox"/>	<input type="checkbox"/>	Has urine leakage affected your quality of life?
		If so, mark on the following scale what point best describes the effect.
		----- ----- ----- ----- -----  Not at all    1        2        3        4        Greatly Affected

C. Gynecologic History

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Last menstrual period Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Irregular/Painful Menstruation
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge/Discomfort
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been pregnant?
		If so, # of children ____ # of pregnancies ____
<input type="checkbox"/>	<input type="checkbox"/>	Painful intercourse
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease

**MEDICAL HISTORY (Check all that you have been diagnosed with):**

A. Pulmonary

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	TB
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Embolism

F. Neurologic

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson Disease
<input type="checkbox"/>	<input type="checkbox"/>	Spinal Cord Injury (Level _____)

B. Cardiovascular

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Valvular Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Prior Angioplasty
<input type="checkbox"/>	<input type="checkbox"/>	History of Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol

G. Gastrointestinal

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis/Pancreatic Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis
<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Bowel Disease (UC/Crohn's)
<input type="checkbox"/>	<input type="checkbox"/>	Hernias
<input type="checkbox"/>	<input type="checkbox"/>	Peptic Ulcer Disease
<input type="checkbox"/>	<input type="checkbox"/>	Gastroesophageal Reflux
<input type="checkbox"/>	<input type="checkbox"/>	GI Bleed
<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids

C. Endocrine

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Hypo/Hyper Thyroidism

H. Renal Disease

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Renal Failure
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones

D. Musculoskeletal

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Fibromyalgia  
 Osteoporosis  
 Arthritis  
 Gout

E. Psychological

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Depression  
 Other \_\_\_\_\_

I. Eyes

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

Glaucoma

J. Hematologic/Immunologic

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Bleeding/Clotting Problems  
 Anemia  
 History of Blood Transfusions  
 HIV/Aids  
 Cancer, if so what type(s)? \_\_\_\_\_

PAST SURGICAL HISTORY (List prior surgical procedures and approximate dates):

_____	_____
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS & DOSAGES (Include Over-the-Counter & Herbal Medicines):

*\*if you filled out this information on the Patient Information Sheet you may skip this section*

_____	_____
_____	_____
_____	_____
_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? \_\_\_\_ Yes (list below) \_\_\_\_ No

*\*if you filled out this information on the Patient Information Sheet you may skip this section*

_____	_____
_____	_____
_____	_____

FAMILY HISTORY (Check all that your family members have been diagnosed with):

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Kidney Cancer  
 Bladder Cancer  
 Kidney Stones

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Heart Disease  
 Other \_\_\_\_\_

**SOCIAL HISTORY (Check all that apply to you):**

YES  NO Tobacco Use If so, What type? \_\_\_\_\_ Amount: \_\_\_\_\_ How long? \_\_\_\_\_  
 If you answered yes and have quit give the date you quit \_\_\_\_\_  
 YES  NO Alcohol Use If so, What type? \_\_\_\_\_ Amount: \_\_\_\_\_ How long? \_\_\_\_\_  
 If you answered yes and have quit give the date you quit \_\_\_\_\_  
 YES  NO Illegal Drug Use If so, What type? \_\_\_\_\_ Amount: \_\_\_\_\_ How long? \_\_\_\_\_  
 If you answered yes and have quit give the date you quit \_\_\_\_\_

Occupation: \_\_\_\_\_ Retired: \_\_\_ Yes \_\_\_ No

Marital Status: \_\_\_ Single \_\_\_ Widowed  
 \_\_\_ Married \_\_\_ Other  
 \_\_\_ Divorced

**REVIEW OF SYSTEMS (Check beside all symptoms you are experiencing):**

*General*

YES  NO  
 Fever  
 Chills  
 Weight Loss  
 Decreased Appetite

*Cardiovascular*

YES  NO  
 Chest Pain  
 Ankle Swelling  
 Palpitations

*Pulmonary*

YES  NO  
 Shortness of Breath  
 Cough  
 Sputum Production

*GI System*

YES  NO  
 Nausea  
 Vomiting  
 Abdominal Pain  
 Diarrhea  
 Bloody Stools  
 Black Tarry Stools

*HEENT*

YES  NO  
 Hearing Loss  
 Nasal Congestion  
 Sore Throat  
 Difficulty Swallowing

*Neurologic*

YES  NO  
 Headaches  
 Numbness/Tingling  
 Memory Loss  
 Blurred Vision  
 Visual Changes

*Musculoskeletal*

YES  NO  
 Weakness  
 Joint Pain

*Hematologic*

YES  NO  
 Swollen Lymph Nodes  
 Nose Bleeds  
 Bruising

*Endocrine*

YES  NO  
 Hot Flashes

*Skin*

YES  NO  
 Rash  
 Skin Cancer

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_