

Swedish Urology Group

Patient History Form – Female

Note: This is a confidential record and will be kept as part of your chart. Information provided here will not be released to anyone without your authorization to do so.

Name: _____ Today's Date: _____

Date of Birth: ____ / ____ / ____ Age: ____ Social Security No: _____

Were you referred to our office by another physician? Yes / No

If yes, name _____ Phone _____

CURRENT PROBLEM

What is the main problem that brings you to the office today? (Describe your symptoms in detail)

When did you first notice the problem or symptoms?: _____

Where in your body do the symptoms arise? _____

Do they travel or go anywhere _____

Had you experienced any similar symptoms in the past? _____

Are the symptoms continuous, variable, or only occasionally present? _____

When present, how long do they last? _____

How severe are the symptoms that arise at the same time? _____

Do you notice any other symptoms that arise at the same time? _____

What seems to make the symptoms worse (activity, food, etc.)? _____

What seems to make the symptoms better? _____

Do the symptoms interfere with your normal function? _____

PAST MEDICAL HISTORY

Please list all illnesses requiring medical treatment, surgery, or hospitalization:

Please list current/recent medications:
(Include dose, how often and date began)

MEDICATION ALLERGIES (Please list reaction)

FAMILY MEDICAL HISTORY

Please list any major illnesses in family members, parents' age or age at death, siblings' age or age at death:

Father _____

Mother _____

Brothers/Sisters _____

Grandparents _____

SOCIAL HISTORY

What is your occupation? _____

Do you smoke currently? Yes/No Years/Amount? _____

Marital Status? _____

Did you smoke in the past? Yes/No Dates _____

Do you live alone? _____

How much alcohol do you drink per day? _____

Number of children? _____

How much caffeine do you use per day? _____

Have you used any recreational drugs? _____

Female Urologic Symptoms/ History

Have you had any of the following in the last six months? Please check/circle any that apply.

- _____ Stones of the kidney, ureter or urinary bladder?
- _____ Cancer of the kidney, ureter, bladder, ovary, uterus, cervix or vulva?
- _____ Infection of the urinary tract (kidney or bladder)?
- _____ Trauma to the kidney, bladder or urethra?
- _____ Herpes, genital warts or gonorrhea?
- _____ Surgery on kidney, bladder, ureters or uterus?
- _____ Endometriosis?
- _____ Pregnancy? (how many births? _____)

General

- Y N fevers
- Y N chills
- Y N sweats
- Y N anorexia
- Y N fatigue
- Y N malaise
- Y N weight loss

Eyes

- Y N blurring
- Y N double vision
- Y N irritation
- Y N discharge
- Y N vision loss
- Y N eye pain
- Y N light sensitivity

Ears/Nose Throat

- Y N earache
- Y N ear discharge
- Y N ringing
- Y N hearing loss
- Y N nasal congestion
- Y N nosebleeds
- Y N sore throat
- Y N hoarseness
- Y N painful swallowing

Breast

- Y N swelling
- Y N masses
- Y N nipple discharge
- Y N pain
- Y N skin changes

Cardiovascular

- Y N chest pains
- Y N palpitations
- Y N dizziness/syncope
- Y N shortness of breath
- Y N short of breath lying down
- Y N sudden nighttime breathlessness
- Y N ankle swelling

Respiratory

- Y N cough
- Y N shortness of Breath
- Y N excessive sputum
- Y N bloody sputum
- Y N wheezing

Gastrointestinal

- Y N nausea
- Y N vomiting
- Y N diarrhea
- Y N constipation
- Y N change in bowel habits
- Y N abdominal pain
- Y N black or tarry stools
- Y N red blood in the stools
- Y N jaundice

Genitourinary

- Y N urethral pain on voiding
- Y N frequent urination
- Y N urgent need to urinate
- Y N difficulty starting stream
- Y N slowing of stream
- Y N intermittent stream
- Y N feeling bladder doesn't empty completely
- Y N urine leak with laugh, cough or strain
- Y N leak with urge to urinate
- Y N getting up at night to urinate
- Y N blood in the urine
- Y N pelvic pain
- Y N vaginal discharge
- Y N vaginal bleeding (non-menstrual)
- Y N labial soreness
- Y N bladder dropping

Musculoskeletal

- Y N back pain
- Y N joint pain
- Y N joint swelling
- Y N muscle cramps
- Y N muscle weakness
- Y N Stiffness
- Y N Arthritis

Skin

- Y N rash
- Y N itching
- Y N dryness
- Y N suspicious lesions

Neurologic

- Y N transient paralysis
- Y N weakness
- Y N tingling numbness
- Y N seizures
- Y N dizziness
- Y N tremors
- Y N room spinning

Psychiatric

- Y N depression
- Y N anxiety
- Y N memory loss
- Y N mental disturbance
- Y N thoughts of suicide
- Y N hallucinations
- Y N paranoia

Endocrine

- Y N cold intolerance
- Y N heat intolerance
- Y N constant thirst
- Y N constant hunger
- Y N frequent urination
- Y N weight gain

Heme/Lymphatic

- Y N abnormal bruising
- Y N bleeding
- Y N low blood count
- Y N enlarged lymph nodes

Allergic/Immunologic

- Y N hives
- Y N hay fever
- Y N persistent infections
- Y N HIV exposure