New Patient Form - Female

Date of Visit________________________

Name:____What do you like to be called?_______________Date of birth?__________

last *first*

Referring physician:__________________________________ Primary care physician:__________________________________

Other physicians you see and why you see them:____

Special needs (wheelchair, etc.):____Height:___________Weight:__________

Current Problem

What is the main reason for your visit?____When did this start?__________________

Describe the location of the problem:_______________How severe is the problem (using a scale of 1-10 with 10 being the worst)?_____

Is the problem present all the time?________________If not, please explain and describe anything that makes the problem better or worse

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Have you had any treatment for this condition? _______If so, please explain: ____

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Have you had any blood tests, X-rays or imaging for this problem? If so, what, where and when?

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PLEASE BRING ALL RECORDS/X-RAYS CD/FILMS TO YOUR APPOINTMENT

Please share anything else you think may be important about your problem.____

Have you ever seen a urologist before? If so, who, when and what for?____

Do you currently have any of the following symptoms? If yes, please explain below.

Fever or chills?	Y	N	Are you awakened at night to urinate? How many times? _______	Y	N
Pain in the side or back?	Y	N	Excessive urge to urinate?	Y	N
Blood in the urine?	Y	N	Leaking of urine when coughing, laughing or movement?	Y	N
Pain during urination?	Y	N	Leaking of urine with urgency?	Y	N
Weak urinary stream?	Y	N	Wear pads due to leaking? How many in 24 hours? _______	Y	N
Difficulty emptying bladder?	Y	N	Problems with sexual function?	Y	N
Excessive frequency of urination	Y	N	Pelvic pain?	Y	N
How many times in 24 hours? ______					

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Have you ever had any of the following? If yes, please explain below.

Bladder infections?	Y	N	Surgery of the urinary tract?	Y	N	Kidney Stones?	Y	N
Kidney infections?	Y	N	Cancer of the urinary tract?	Y	N	Other urologic problems?	Y	N

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Number of pregnancies__________Vaginal births_________C-Sections___________Date of last menstrual period__________________

Menopause/Hysterectomy____________________________Endometriosis YES NO Other____

Medications (*please include over the counter medications and supplements, include seperate sheet of paper if more space is needed)*

Medication	***Dosage***	***Freq.***	***Medication***	***Dosage***	***Freq.***

Do you take any blood thinners? (aspirin, Coumadin, Plavix, etc.) Y N Type ____

ALLERGIES____

MEDICAL CONDITIONS AND PAST MEDICAL HISTORY,

If yes to any, please explain below.

Diabetes	Y	N	Emphysema	Y	N	________
High blood pressure	Y	N	Asthma	Y	N	________
High cholesterol	Y	N	Major trauma	Y	N	________
Heart valve problem	Y	N	Parkinson's disease	Y	N	________
Heart attack	Y	N	Stroke/TIA	Y	N	________
Hepatitis	Y	N	HIV	Y	N	________
Bleeding tendency	Y	N	Depression	Y	N	________
Blood clots	Y	N	Psychiatric disorders	Y	N	________
Pacemaker/difib implant	Y	N	Glaucoma	Y	N	________

Have you ever had cancer? ____________type? ____________status? ____________

OTHER MEDICAL PROBLEMS

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PRIOR SURGERIES (please include date)

________________________ ________________________

________________________ ________________________

________________________ ________________________

HABITS Smoking N Y QUIT If quit, what year?________Packs per day?________How many years did (have) you smoke(d)?_______

Alcohol N Y Drinks per week?__________Recreational drugs?______________________

Occupation____________________Marital Status______________No. of Children________

Have you ever been exposed to radiation or environmental toxins NO YES ______________________

FAMILY MEDICAL HISTORY

Has anyone in YOUR FAMILY (other than yourself) ever had the following?

Kidney Stones__________Cancer of the kidney or bladder__________Cancer of the breast, uterus, cervix, or ovaries__________

Mother: age____if deceased, age________cause____________**Father:** age_____if deceased, age_________cause____________

Do you currently have any of the following symptoms? If so, please explain below:

Problems with general health	Y	N	Abdominal pain	Y	N	Seizures	Y	N
Recent weight change	Y	N	Diarrhea	Y	N	Tremors	Y	N
Fatigue	Y	N	Constipation	Y	N	Numbness/tingling	Y	N
Sore throat	Y	N	Poor appetite	Y	N	Depression	Y	N
Recent cold	Y	N	Heat/cold intolerance	Y	N	Insomnia	Y	N
Irregular heart beat	Y	N	Joint pain/stiffness	Y	N	Thyroid disease	Y	N
Chest pain	Y	N	Back pain	Y	N	Excessive thirst	Y	N
Shortness of breath	Y	N	Rash	Y	N	Anemia	Y	N
Chronic cough	Y	N	Itching	Y	N	Past blood transfusion	Y	N
Nausea/Vomiting	Y	N	Frequent headaches	Y	N	Easy bleeding/bruising	Y	N

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