

SWEDISH UROLOGY

# 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 Number: \_\_\_\_\_

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? \_\_\_\_\_ How much alcohol do you drink per day? \_\_\_\_\_

Marital status? \_\_\_\_\_ How much caffeine do you use per day? \_\_\_\_\_

Do you live alone? \_\_\_\_\_ Have you used any recreational drugs?  Yes  No

Number of children? \_\_\_\_\_

Do you smoke?  Yes  No If yes, years/amount: \_\_\_\_\_

Did you smoke in the past?  Yes  No If yes, dates: \_\_\_\_\_ (over)



## FEMALE UROLOGIC SYMPTOMS/HISTORY

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

### General

- Y N Stones of the kidney, ureter or urinary bladder?
- Y N Cancer of the kidney, ureter, bladder, ovary, uterus, cervix or vulva?
- Y N Infection of the urinary tract (kidney or bladder)?
- Y N Trauma to the kidney, bladder or urethra?
- Y N Herpes, genital warts or gonorrhea?
- Y N Surgery on kidney, bladder, ureters or uterus?
- Y N Endometriosis?
- Y N Pregnancy (how many births \_\_\_\_\_)?
- 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 Shortness 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 urine stream
- Y N Intermittent urine 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 Pelvin 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

We do not discriminate on the basis of race, color, national origin, sex, age, or disability in our health programs and activities.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-313-9127 (Swedish Edmonds 888-311-9178) (TTY:711)

注意：如果您講中文，我們可以給您提供免費中文翻譯服務，請致電 888-313-9127 (Swedish Edmonds 888-311-9178) (TTY:711)