

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

Have you had any treatment for this condition? _____ If so, please explain: _____

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

PLEASE BRING ALL RECORDS/X-RAYS CD/FILMS TO YOUR APPOINTMENT (not required if tests were done at CDH)

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? _____					

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

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 separate sheet of paper if more space is needed)

<i>Medication</i>	<i>Dosage</i>	<i>Freq.</i>	<i>Medication</i>	<i>Dosage</i>	<i>Freq.</i>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Do you take any blood thinners? (asprin, 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

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

