ADULT FEMALE HISTORY FORM
UROLOGIC SPECIALISTS OF OKLAHOMA, INC.

Revised December 2009-UC

Please complete all sections

DATE:

PLEASE LIST ALL DRUG ALLERGIES

Latex Rubber: Yes No Unknown
Shellfish: Yes No Unknown
X-Ray Dye: Yes No Unknown
Past problems w/ Anesthesia Yes No Unk
Past transfusion reactions Yes No Unk

PATIENT NAME:
DOB:
PRIMARY PHYSICIAN:
REFERRING PHYSICIAN:

MEDICATIONS

Please list all medications you currently use: (including over the counter drugs i.e. aspirin)

Name	Dose	Frequency	Last Dose

ADULT FEMALE GENITOURINARY HISTORY

YES	NO		WHEN?
		Burning when urinating	
		Don't get to bathroom in time	
		Blood in Urine	
		Pain in your kidneys	
		Pain in your bladder	
		Slow stream	
		Difficulty emptying the bladder	
		Urinary Tract Infections	
		Urinary Tract Stones	
		Leakage of Urine	

How frequently do you urinate during the day?
How frequently do you urinate during the night?
How many pregnancies?
How many children? **Ages?**
Do you have any problems with sexual functioning? **YES** **NO**
Explain:

SURGERY/HOSPITALIZATION HISTORY
(LIST ALL OPERATIONS/PROCEDURES WITH DATES)

MEDICAL HISTORY (LIST ALL HEALTH PROBLEMS)

FAMILY HISTORY **(INCLUDE DIAGNOSIS & RELATIONSHIP)**

SOCIAL HISTORY

WHAT CITY DO YOU LIVE IN? OCCUPATION?
MARITAL STATUS:
DO YOU USE TOBACCO? **YES** **NO** **HOW MUCH?**
DO YOU DRINK ALCOHOL? **YES** **NO** **HOW MUCH?**
HOW MANY CAFFIENE DRINKS PER DAY?
HAVE YOU HAD A BLOOD TRANSFUSION?

DESCRIBE YOUR PROBLEM:

Yes	No	REVIEW OF SYSTEMS
		GENERAL SYMPTOMS
		Fever
		Recent weight loss/gain
		CARDIOVASCULAR (HEART)
		Irregular Heart Beat
		Chest Pain
		Heart Attack (s)
		Mitral Valve Prolapse or Heart Murmur
		High Blood Pressure
		RESPIRATORY
		Shortness of Breath
		Wheezing
		Emphysema
		Cough
		GASTROINTESTINAL
		Abdominal Pain
		Stomach Ulcers
		Hiatal Hernia/Reflux
		Jaundice
		Nausea
		MUSCULOSKELETAL
		Arthritis
		Back Pain
		NEUROLOGICAL
		Stroke
		Dizziness
		Weakness
		ENDOCRINE
		Thyroid Disease
		Diabetes
		BLOOD DISORDERS
		Anemia
		Bleeding Tendencies
		CANCER
		Bladder
		Breast
		Kidney
		Ovarian
		Other:

Yes	No	FAMILY HISTORY
		Has anyone in your family had?
		Bladder Cancer
		Kidney Cancer
		Other Cancer?

VITAL SIGNS

BP:
RESP:
HR:
PULSE:
TEMP: