FEMALE PATIENT QUESTIONNAIRE/HISTORY FORM

Name: _____ Age: _____

Today's Date: _____ Family Physician: _____

This questionnaire is very important! These questions are designed to aid your Doctor in assessing your problem, so please try to answer each question concisely and accurately. All information in this report and in this office is kept in the strictest confidence.

CHIEF COMPLAINT: What is the main reason for your visit today? Be precise.

_____

_____

Urinary Symptoms: Check appropriate box		Yes	No
1.	Burning on urination:	☐	☐
2.	Urinating frequent, small amounts	☐	☐
3.	Feeling like you need to urinate urgently! "or else…"	☐	☐
4.	Lower abdominal "Pressure"	☐	☐
5.	Do you awaken at night to urinate? If YES, how many times? _____	☐	☐
6.	Pass or air "gas" in the urine	☐	☐

Urinary Tract infections: Check appropriate box	Yes	No
1. Have you ever had any previous urinary infections (cystitis)? (if none, go on to next section) a) How many? _____ b) Last infection _____ c) At what age did they start? _____ d) Related to sexual activity? _____	☐	☐
2. Did you ever have a high fever (102) with a urinary infection?	☐	☐
3. Did you ever have pain in the flank or kidneys with a urinary infection?		
4. Have you ever had X-rays of the kidneys (IVP) or bladder (Voiding Cystogram)?	☐	☐
5. Were you ever hospitalized to treat a urinary infection?	☐	☐
6. Have you ever had a sexually transmitted disease? (Circle - gonorrhea, chlamydia, herpes, genital warts, PID, other _____)	☐	☐

Incontinence:	**Yes**	**No**
1. Do you have leakage of urine (wetting of the pants) with:		
a. Sneezing, coughing, straining	☐	☐
b. Laughing, walking	☐	☐
c. Upon arising from a sitting position	☐	☐
d. Sudden urge to urinate/ cannot hold it until you get to the bathroom?	☐	☐
e. During sexual intercourse?	☐	☐
2. Do you use any pads for protection? How many per day? _____	☐	☐
3. Do you have to push or strain to empty the bladder?	☐	☐
4. Have you ever had a bladder suspension surgery?	☐	☐
If yes…		
Through the abdomen?	☐	☐
Through the vagina?	☐	☐

	YES	NO
KIDNEY STONES		
1. Do you have pain in the flank or kidney area? If YES, Left _____ Right _____	☐	☐
2. Have you ever had a kidney stone? If not, go to the next section.	☐	☐
If YES a. When? _____ b. How many? _____ c. Passed spontaneously? _____ d. Removed 1. Surgically: _____ 2. Basket? _____ e. Lithotripsy (shock waves)? _____		
What was the stone made of? Calcium? _____ Uric Acid? _____ Other? _____		
Was a metabolic evaluation done to determine the cause of the stone?	☐	☐
Were you placed on stone prevention therapy? What? _____	☐	☐

HEMATURIA	**YES**	**NO**
1. Have you seen blood in your urine? (If no, go to question #3)	☐	☐
If YES a. Was the blood only at the beginning of the stream?	☐	☐
b. Throughout the stream?	☐	☐
c. At the end of the stream?	☐	☐
Was the bloody urine (check all that apply) a. Tea colored ☐ b. Rose wine/ cranberry colored ☐ c. Burgundy wine colored ☐ d. Clots ☐		
2. Was there any pain or burning with the bloody urine?	☐	☐
3. Has a doctor found blood in your urine under a microscope?	☐	☐

PAST MEDICAL HISTORY / REVIEW OF SYSTEMS

Have you ever had any serious problems with…	**YES**	**NO**	**DESCRIBE**
HEART (chest pain, heart attack, murmur, irregular heartbeat, high blood pressure, heart failure, etc.)	☐	☐	
LUNGS (shortness of breath, emphysema, asthma, TB, pneumonia, etc.)	☐	☐	
BREAST (cancer)	☐	☐	
STOMACH / LIVER (ulcers, bleeding, hepatitis, etc.)	☐	☐	
BOWELS (change in bowel habits, CONSTIPATION, diarrhea)	☐	☐	
GYNECOLOGIC SYSTEM (FEMALE ORGANS)			
BRAIN / NERVOUS SYSTEMS (stroke, seizure, "blackout spells," etc.)	☐	☐	
GLANDS (DIABETES, thyroid, gout)	☐	☐	
MUSCULOSKELETAL (arthritis, disc disease)	☐	☐	
EYES / EARS / NOSE / THROAT	☐	☐	
BLOOD OR CLOTTING PROBLEMS	☐	☐	
PSYCHIATRIC (depression, mental illness)	☐	☐	
CONSTITUTIONAL (unexplained weight loss, fevers, chills, night sweats)	☐	☐	
CANCER (kidney, bladder)	☐	☐	
SKIN (rash, psoriasis, hives)	☐	☐	
Do you have any artificial joints or heart valves?	☐	☐	

REPRODUCTIVE HISTORY

	YES	NO
1. How many times have you been pregnant? _____		
2. How many children do you have? _____		
3. How many Cesarean Sections? _____		
4. Have you ever had a miscarriage? Y or N If yes, how many? _____		
5. Have you ever had an Abortion? Y or N If yes, how many? _____		
6. Last menstrual period started _____		
7. Menopause started _____		
8. Have you have a hysterectomy?	☐	☐
If YES:		
Reason? _____		
Through the abdomen?	☐	☐
Through the vagina?	☐	☐
Tubes and ovaries removed?	☐	☐
9. Are you sexually active?	☐	☐
10. Do you frequently have pain with intercourse?	☐	☐

SURGICAL HISTORY

OPERATION	DATE	SURGEON
1.		
2.		
3.		
4.		
5.		

Have you ever had a blood transfusion? Yes ☐ No ☐ If so, when? _____

MEDICATIONS

NAME OF MEDICATION	DOSAGE (mg)	HOW TAKEN (ex: one pill twice a day)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

ALLERGIC REACTIONS

Please list all medications that give you a rash, hives, wheezing, difficulty breathing, shock, etc.

NAME OF MEDICATION	SPECIFY TYPE OF REACTION
1.	
2.	
3.	

DRUG INTOLERANCES

Please list all medications that caused side effects such as nausea, vomiting, stomach upset, diarrhea, headache, etc.

NAME OF MEDICATION	SPECIFY TYPE OF REACTION
1.	
2.	
3.	

FAMILY HISTORY

Please list any diseases that run in your family such as cancer, kidney stones, diabetes, etc.

DISEASE	FAMILY MEMBER
1.	
2.	
3.	
4.	

SOCIAL HISTORY	YES	NO
1. Do you smoke, or did you ever smoke? How much? _____ packs / day _____ How long? _____ years Quit when? _____	☐	☐
2. Do you drink? How much? _____	☐	☐
3. Do you use street drugs? What type? _____ Do you use needles? _____	☐	☐
4. Do you engage in "high risk" sexual behavior?	☐	☐
5. Are you HIV positive or do you have AIDS?	☐	☐
6. Circle one - employed/ retire/ homemaker/ unemployed Type of employment? _____	☐	☐
7. Circle one - married/ single/ divorced	☐	☐