Print Form

Swedish Urology Group

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 No: _____

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?_____
Marital Status? _____
Do you live alone?_____
Number of children?_____

Do you smoke currently? Yes/No Years/Amount?_____
Did you smoke in the past? Yes/No Dates _____
How much alcohol do you drink per day? _____
How much caffeine do you use per day?_____
Have you used any recreational drugs?_____

Female Urologic Symptoms/ History

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

- ☐ Stones of the kidney, ureter or urinary bladder?
- ☐ Cancer of the kidney, ureter, bladder, ovary, uterus, cervix or vulva?
- ☐ Infection of the urinary tract (kidney or bladder)?
- ☐ Trauma to the kidney, bladder or urethra?
- ☐ Herpes, genital warts or gonorrhea?
- ☐ Surgery on kidney, bladder, ureters or uterus?
- ☐ Endometriosis?
- ☐ Pregnancy? (how many births?_____)

General

- ☐ 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 short 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 stream
- ☐ Y ☐ N intermittent 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 pelvic 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