PATIENT HISTORY FORM

NOTE: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

LAST NAME: ____________________ FIRST NAME: _____________________ DOB: ____________ DATE: ____________

Review of Systems

Do you now or have you had problems related to the following systems:

Circle YES or NO

Constitutional Symptoms		**Comments**	**Musculoskeletal**		**Comments**
Weight Change	Y N		Bone Pain	Y N	
Chills/Fever	Y N		Muscle Pain	Y N	
Sleep Disorder	Y N		Joint Pain	Y N	
Eyes			**Integument (skin)**		
Double Vision	Y N		Rash	Y N	
Glaucoma	Y N		Lumps or Bumps	Y N	
Cataracts	Y N		Moles, Skin Tags	Y N	
Ear/Nose/Throat/Mouth			**Respiratory**		
Hearing Changes	Y N		Wheezing	Y N	
Sore Throat	Y N		Frequent Cough	Y N	
Sinus Problem	Y N		Shortness of Breath	Y N	
Cardiovascular			**Neurological**		
Chest Pain	Y N		Tremors	Y N	
Irregular Heartbeat	Y N		Dizzy Spells	Y N	
Swelling in Ankles	Y N		Numbness/Tingling	Y N	
Psychological			**Gastrointestinal**		
Are you generally happy?	Y N		Abdominal Pain	Y N	
Do you feel depressed?	Y N		Nausea/Vomiting	Y N	
Do you feel anxious?	Y N		Indigestion/Heartburn	Y N	
Do you feel safe in your home?	Y N		Constipation/Diarrhea	Y N	
			Other:		
Endocrine			**Genitourinary**		
Excessive Thirst	Y N		Urinary Incontinence (loss of urine)	Y N	
Too Hot/Cold	Y N		- Spontaneous	Y N	
Tired/Fatigued	Y N		- With Activity	Y N	
Irregular Periods	Y N		Urinary Frequency>8 times/day	Y N	
Heavy Bleeding	Y N		Painful Urination	Y N	
Bleeding after Menopause	Y N				
Hematologic/Lymphatic			**Sexual History**		
Swollen Glands	Y N		Are you currently sexually active?	Y N	
Blood Clotting Problems	Y N		Heterosexual or Homosexual (circle one)		
Bruising	Y N		Have you ever been sexually active?	Y N	
			Method of Contraception ______________		
			Change in sex drive	Y N	
			Painful Intercourse	Y N	
			Sexual Trauma	Y N	
Allergic/Immunologic					
Hay Fever	Y N				
Drug Allergies	Y N				
Food Allergies	Y N				
Other:					

Patient Signature: ____ Date: _________________________

Physician Signature: ____ Date: _________________________

MEDICAL HISTORY FORM

LAST NAME: ______________________FIRST NAME: ________________________ DOB: ___________________ DATE: ________________

Medical ◻ None (High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.)________________
____
____
____
____

Pregnancy History

Year	Sex	Complications
____	____	_______________________
____	____	_______________________
____	____	_______________________
____	____	_______________________

Surgical ◻ None (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.)
____
____
____
____
____

Gyn/Breast/Colon History
Last Pap: ______________________________
Last Mammo: __________________________
Colonoscopy: __________________________
Sigmoidoscopy: _________________________
Regular Periods? ________________________
Length of Periods? ______________________

Allergies to Medications None (If yes, explain type of reaction, i.e. hives, wheezing, upset stomach, swelling etc.)
____
____

Current Prescription Medicines None

Name of Drug	mg dose	#tablets	#times per day
____________	_______	_______	_________
____________	_______	_______	_________
____________	_______	_______	_________

Current Prescription Medicines (cont'd)

Name of Drug	mg dos	#tablets	#times day
____________	_______	_______	________
____________	_______	_______	________
____________	_______	_______	________

FAMILY HISTORY

	Living	Deceased	Illness	Cause of Death/Illness
Father	◻	◻	____________________	____________________
Mother	◻	◻	____________________	____________________
Sister (s)	◻	◻	____________________	____________________
Brother (s)	◻	◻	____________________	____________________

Other Family History:	Yes	No	Family Member		Yes	No	Family Member
Heart Disease	◻	◻	_____________	Osteoporosis	◻	◻	______________
Cancer (type)	◻	◻	_____________	Thyroid Problems	◻	◻	______________
Diabetes	◻	◻	_____________	Endometriosis	◻	◻	______________
Alcohol Abuse	◻	◻	_____________	Other	◻	◻	______________

SOCIAL HISTORY

Smoke? ◻ Yes ◻ No If yes, # of packs per day: _____ # of years: _____ When did you stop smoking? _______
Alcohol: ◻ Yes ◻ No If yes, how many drinks per week? _______
Occupation? ______________________________
◻ Coffee- How much? _________________ ◻ Tea- How Much? _______________ ◻ Soda- How much?_____________________
Have you ever used recreational drugs? (i.e. marijuana, cocaine) If yes, what/when:
____
Domestic Violence?
____

Patient Signature: ____ Date: ______________

Physician Signature: ____ Date: ______________

AZ UROGYNECOLOGY

BLADDER SYMPTOM INTAKE FORM

NAME: ___________________________________ DOB: ____________ DATE:____________

*Do you have leakage of urine with laughing, coughing, sneezing or exercising? (YES) (NO)

If yes, how many times? _____per day or _____per week

*Do you have leakage of urine before reaching the bathroom? (YES) (NO)

If yes, how many times? _____per day or _____ per week

*Do you have sudden unexpected leakage of urine? (YES) (NO)

*How many times do you go to the bathroom to urinate along the day? _____times/day

*How many times do you wake up during the night to urinate if any? _____ times/night

*Do you feel a burning sensation when you urinate? (YES) (NO)

*Do you feel bladder pain, pressure or discomfort? (YES) (NO)

*Did you ever see blood in the urine? (YES) (NO)

*Have you tried any bladder medications before?

If yes, circle the medication(s) that you have tried-

(Detrol LA, Ditropan, Oxybutinin, Sanctura, Enablex, Vesicare, Toviaz, Oxytrol patch,

Or other: ____________________________)

*Did you have anti-leakage surgical procedure(s) in the past? (YES) (NO)

If yes, please write the procedure name and date: ____

*Do you feel that you completely empty your bladder after urination? (YES) (NO)

*Do you feel any bulge or pressure in the vagina? (YES) (NO)

PATIENT SIGNATURE: ____ DATE:_________________

PHYSICIAN SIGNATURE: ____ DATE:_________________