

**WICHITA UROLOGY GROUP, P.A.
FEMALE MEDICAL HISTORY**

NAME _____ DOB _____ AGE _____

FAMILY DOCTOR _____ REFERRING DOCTOR _____

OTHER DOCTORS CARING FOR YOU _____

REASON FOR VISIT / CHIEF COMPLAINT _____

UROLOGICAL PROBLEMS (CIRCLE ALL THAT APPLY)

- | | |
|---|--|
| BURNING WITH URINATION | BLOOD IN URINE |
| SLOW URINARY STREAM | KIDNEY / BLADDER INFECTION |
| DIFFICULTY STARTING STREAM | KIDNEY / BLADDER STONE |
| INABILITY TO HOLD URINE | CYSTOCELE (FALLEN BLADDER) |
| FREQUENT URINATION | KIDNEY CANCER |
| URINATING AT NIGHT | BLADDER CANCER |
| BEDWETTING | INTERSTITIAL CYSTITIS |
| BLADDER FISTULA (HOLE IN BLADDER) | I HAVE HAD X-RAYS OF KIDNEY / BLADDER |

OB/GYN (CIRCLE ALL THAT APPLY)

- | | |
|--|--------------------------------------|
| NUMBER OF PREGNANCIES _____ | VAGINAL INFECTIONS |
| NUMBER OF CHILDREN _____ | SEXUALLY TRANSMITTED DISEASES |
| CURRENTLY PREGNANT | CURRENTLY BREAST FEEDING |
| MY PERIODS ARE NORMAL | C-SECTION |
| CURRENTLY ON BIRTH CONTROL | TUBAL LIGATION |
| IF YES, WHAT KIND OF BIRTH CONTROL | ENDOMETRIOSIS |
| _____ | OVARIAN CANCER |
| _____ | CERVICAL CANCER |
| ECTOPIC (TUBAL) PREGNANCY | BREAST CANCER |
| CURRENTLY TAKING FERTILITY MEDICATION | BREAST SURGERY |
| I HAVE GONE THROUGH MENOPAUSE | SURGERY ON UTERUS OR OVARIES |

LIST ALL MEDICAL PROBLEMS (INCLUDING DIABETES, HYPERTENSION, ETC.)

LIST ALL PRIOR SURGERIES AND DATES

LIST ALL CURRENT MEDICATIONS AND DOSAGES

(INCLUDE OVER-THE-COUNTER MEDICATIONS AND HERBS)

LIST MEDICATION ALLERGIES AND TYPE OF REACTION

ANY REACTION TO IODINE? TYPE OF REACTION

FAMILY HISTORY

IF EITHER PARENT IS DECEASED, LIST CAUSE OF DEATH _____

DO YOU HAVE A FAMILY HISTORY OF: (CIRCLE ALL THAT APPLY)

BLADDER CANCER KIDNEY CANCER STROKE DIABETES
PROSTATE CANCER HEART ATTACK KIDNEY PROBLEMS

SOCIAL HISTORY

OCCUPATION (PREVIOUS OCCUPATION IF RETIRED) _____

MARITAL STATUS _____ NUMBER OF CHILDREN _____

ALCOHOL CONSUMPTION _____ TOBACCO USE (NOW OR IN PAST) _____

REVIEW OF SYSTEMS

CONSTITUTIONAL

WEIGHT LOSS Y N
WEIGHT GAIN Y N
FATIGUE / WEAKNESS Y N
FEVER Y N

EYES / EARS / NOSE / THROAT

GLAUCOMA Y N
HEARING PROBLEMS Y N
SORE THROAT Y N
SINUS PROBLEMS Y N

NEUROLOGICAL

MULTIPLE SCLEROSIS Y N
PARKINSON'S Y N
BACK / SPINAL CORD INJURY Y N
SEIZURE / EPILEPSY Y N
NUMBNESS / TINGLING Y N

RESPIRATORY

COUGH Y N
BLOOD IN SPUTUM Y N
SHORTNESS OF BREATH Y N
ASTHMA Y N
COPD / EMPHYSEMA Y N

CARDIOVASCULAR

CHEST PAIN Y N
PALPITATIONS Y N
LEG PAIN WITH EXERTION Y N
HEART ATTACK Y N
STROKE Y N

GASTROINTESTINAL

STOMACH PAIN Y N
HEPATITIS Y N
ULCERS Y N
BLOOD IN STOOLS OR BLACK STOOLS Y N
DIARRHEA / CONSTIPATION Y N
NAUSEA / VOMITING Y N

HEMATOLOGICAL

ARE YOU TAKING COUMADIN? Y N
EASY BRUISING Y N
BLEEDING PROBLEM Y N

MUSCULOSKELETAL

JOINT PAIN Y N
BACK PAIN Y N

SKIN

RASHES Y N
ITCHING Y N

ENDOCRINE

DIABETES Y N
HIGH BLOOD PRESSURE Y N
THYROID DISEASE Y N
LOSS OF HAIR Y N
HEAT / COLD INTOLERANCE Y N

PSYCHIATRIC

DEPRESSION Y N
ANXIETY Y N

SIGNATURE OF PATIENT / PATIENT REPRESENTATIVE

DATE SIGNED