ADVANCED UROLOGY
CENTERS OF NEW YORK
A Division of Integrated Medical Professionals, PLLC

Female Patient History Form

First Name:_____ Last Name:_____

Date of Birth:_____ Today's Date:_____

History of Present Illness

Reason for today's visit:_____

How long has this problem been occurring? ____days; ____weeks; ____ months; ____years

Does anything make the problem better? _____

Does anything make the problem worse? _____

Does the problem come and go or is it always there?_____

If there is pain, where is the pain located? _____

If there is pain, describe the pain: _____

If there is pain, on a scale of 1-10 (10 being most severe), describe the severity of the pain: _____

Review of Systems—Indicate if you are experiencing or have recently experienced any of the following:

General			Digestive		
Chills	☐Yes	☐No	Abdominal pain	☐Yes	☐No
Fever	☐Yes	☐No	Constipation	☐Yes	☐No
Fatigue	☐Yes	☐No	Nausea/Vomiting	☐Yes	☐No
Skin			**Musculoskeletal**		
Bruising	☐Yes	☐No	Back pain	☐Yes	☐No
Itching	☐Yes	☐No	Joint pain	☐Yes	☐No
Rash	☐Yes	☐No	Muscle pain	☐Yes	☐No
Head and Neck			**Neurological**		
Headache	☐Yes	☐No	Dizziness	☐Yes	☐No
Ringing in the ear	☐Yes	☐No	Seizures	☐Yes	☐No
Nasal congestion	☐Yes	☐No	Weakness	☐Yes	☐No
Lungs			**Endocrine**		
Shortness of breath	☐Yes	☐No	Appetite changes	☐Yes	☐No
Cough	☐Yes	☐No	Excessive thirst	☐Yes	☐No
Wheezing	☐Yes	☐No	Hot flashes	☐Yes	☐No
Cardiovascular			**Hematology**		
Chest pains	☐Yes	☐No	Blood clots	☐Yes	☐No
Palpitations	☐Yes	☐No	Enlarged lymph nodes	☐Yes	☐No
			Prolonged bleeding	☐Yes	☐No

Female Genitourinary—Indicate if you are experiencing or have recently experienced any of the following:

Blood in urine	☐Yes	☐No	Hesitancy	☐Yes	☐No
Urinating at night	☐Yes	☐No	Pelvic pain	☐Yes	☐No
Painful urination	☐Yes	☐No	Pain with intercourse	☐Yes	☐No
Frequency	☐Yes	☐No	Urinary retention	☐Yes	☐No
Inability to hold urine	☐Yes	☐No	Urinary tract infection	☐Yes	☐No
Change in urinary stream	☐Yes	☐No	Vaginal bleeding	☐Yes	☐No
Difficulty emptying bladder	☐Yes	☐No	Vaginal discharge	☐Yes	☐No
Incomplete bladder emptying	☐Yes	☐No	Vaginal dryness	☐Yes	☐No
Flank pain	☐Yes	☐No	Vaginal itching/burning	☐Yes	☐No

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Past Medical History— Have you ever had or do you currently have any of the following?

Anemia	☐	Crohn's Disease	☐	High Blood Pressure	☐
Arthritis	☐	Depression	☐	High Cholesterol	☐
Asthma	☐	Diabetes	☐	HIV/AIDS	☐
Atrial Fibrillation	☐	Diverticulitis	☐	Kidney stones	☐
Back problems	☐	GERD	☐	Renal Insufficiency	☐
Bleeding disorder	☐	Irritable Bowel Syndrome	☐	Sleep Apnea	☐
Cancer	☐	Heart Attack	☐	Stroke	☐
Congestive Heart Failure	☐	Hemorrhoids	☐	Thyroid disease	☐
Coronary Artery Disease	☐	Hepatitis	☐		
COPD	☐	Hernia	☐		

Clarify any checked answers above which require explanation (ie: type of Cancer):_____

_____

_____

List any Medical History not mentioned above: _____

_____

_____

_____

Allergies:

☐ No Known Allergies ☐ No Known Drug Allergies

List allergies to Medications, Food, etc: _____

_____

_____

Do you have reactions to iodine?	☐Yes	☐No
Do you have reactions to seafood?	☐Yes	☐No
Do you have reactions to x-ray dye?	☐Yes	☐No

Family History:

Problem	Father	Mother	Sibling	Other
Bladder Cancer	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐
Kidney Cancer	☐	☐	☐	☐
Other Cancer - Specify:_____	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐

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Social History:

Do you currently smoke?	☐Yes	☐No	If yes, how much?_____	If yes, how long?____
Are you a former smoker?	☐Yes	☐No	If yes, what year did you start?_____	What year did you quit? _____
Do you drink alcohol?	☐Yes	☐No	If yes, how much?_____	How often?_____
Do you or have you ever used drugs?	☐Yes	☐No		

Medications—Please list all medications, including vitamins, herbs, supplements, and over the counter:

Name	Amount	Times per day	Name	Amount	Times per day

Have you ever been told that you need to take antibiotics before dental procedures? ☐Yes ☐No

Pregnancy/Birth History:

Have you ever been pregnant? ☐Yes ☐No

How many pregnancies have you had? _____

How many vaginal births have you had? _____

How many cesarean sections have you had? _____

Is it possible that you are currently pregnant? ☐Yes ☐No

Surgical History—List all surgeries and dates; include side of the body (ie: left knee surgery):

_____

_____

_____

_____

Diagnostic Studies/Health Maintenance:	**Vital signs:**
Last Mammogram: _____	Current Height: ____' ____"
Last Pap Smear: _____	Current Weight: _____lbs.
Last Colonoscopy:_____	