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BASS MEDICAL GROUP

PATIENT HISTORY FORM (FEMALE)

DATE _____/_____/_____

NAME _____ **PRIMARY CARE DOCTOR** _____

REASON FOR VISIT _____

PAST MEDICAL HISTORY

Please check whether you have or have had any of the following conditions:

Diabetes	☐ Yes ☐ No	High cholesterol	☐ Yes ☐ No
High blood pressure/Hypertension	☐ Yes ☐ No	COPD/emphysema	☐ Yes ☐ No
Coronary artery disease	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Congestive heart failure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Chronic renal failure	☐ Yes ☐ No	Dementia (e.g., Alzheimer's)	☐ Yes ☐ No
Atrial fibrillation	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No
Type _____		Hepatitis C	☐ Yes ☐ No
Type _____		HIV	☐ Yes ☐ No

Others:

PAST SURGICAL HISTORY

Please list all prior surgeries:

Surgery	Year	Surgery	Year

MEDICATIONS

Please list all current medications, including vitamins:

Name of medication	Dose	Frequency

ALLERGIES

Please list all drug allergies:

Drug	Reaction

SEE ATTACHED ☐

Reviewed by MD & discussed with patient _____

UROLOGIC HISTORY

Kidney stones

Have you ever had kidney stones? (***If no, skip to next section.***) ☐ Yes ☐ No
How many? Right: _____ Left: _____
When was your most recent stone? _____
Have you ever needed a surgical procedure for stones? ☐ Yes ☐ No
- ☐ ESWL (shock lithotripsy)
- ☐ Ureteroscopy
- ☐ PCNL (percutaneous lithotripsy – through a hole in the back)
- ☐ Open stone surgery (flank or abdominal incision)

Urinary tract infections

Have you ever had a urinary tract infection (UTI)? (***If no, skip to next section.***) ☐ Yes ☐ No
How old were you when you had your first UTI? _____
When was your last UTI? _____
On average, how many UTIs do you get per year? _____

Have you ever had a kidney infection? ☐ Yes ☐ No
If so, which side? ☐ Right ☐ Left ☐ Both

What are your typical UTI symptoms? (check all that apply)
☐ Fever ☐ Burning ☐ Frequency ☐ Urgency (gotta go now!) ☐ Suprapubic pain ☐ Flank pain
☐ Foul smell ☐ Other: _____

Do your infections seem to be related to sexual intercourse? ☐ Yes ☐ No

Urinary symptoms

How often do you urinate during the day? Every _____ hours
How often do you get up to urinate at night? _____
Does it burn or sting when you urinate? ☐ Yes ☐ No
Do experience "urgency" (the need to go *right away*)? ☐ Yes ☐ No

Do you find it difficult to *start* urinating? ☐ Yes ☐ No
Do you have to push or strain to urinate? ☐ Yes ☐ No
Do you feel that you have a weak stream? ☐ Yes ☐ No
Does your urination start and stop? ☐ Yes ☐ No
Do you dribble urine after you finish? ☐ Yes ☐ No
Do you feel that you are unable to empty your bladder completely? ☐ Yes ☐ No
Have you ever needed to be catheterized because you couldn't urinate? ☐ Yes ☐ No
Has your urethra ever been stretched or dilated? ☐ Yes ☐ No

Have you ever seen blood in the urine? ☐ Yes ☐ No
Have you recently seen blood in the urine? ☐ Yes ☐ No

Reviewed by MD & discussed with patient _____

UROLOGIC HISTORY (continued)

Incontinence

Do you ever leak urine? (***IF NO, SKIP TO THE NEXT SECTION.***) ☐ Yes ☐ No
How many pads do you use per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ Other _____

Do you ever leak with straining or exertion? ☐ Yes ☐ No

Running?	☐ Yes	☐ No	Lifting?	☐ Yes	☐ No
Walking?	☐ Yes	☐ No	Coughing?	☐ Yes	☐ No
Jumping?	☐ Yes	☐ No	Sneezing?	☐ Yes	☐ No
Rising quickly?	☐ Yes	☐ No	Laughing?	☐ Yes	☐ No

This "stress" incontinence occurs:
☐ Rarely ☐ 1-3 times per week ☐ 1-3 times per day ☐ 4-6x daily ☐ Constantly

Do you ever leak urine because you can't get to the bathroom in time?
☐ Never ☐ Rarely ☐ 1-3 times per week ☐ 1-3 times per day ☐ 4-6x daily ☐ Constantly

When you get the urge to urinate, how long can you hold it?
☐ As long as necessary. ☐ A few minutes. ☐ 1 minute. ☐ A few seconds. ☐ Not at all.

Do you ever leak when you are sitting or lying still? ☐ Yes ☐ No

Sexually transmitted (venereal) diseases (STDs)

Do you have any urethral discharge? ☐ Yes ☐ No
Have you ever had an STD? (check all that apply) ☐ Yes ☐ No
☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ HIV ☐ Other _____

Gynecologic history

Number of pregnancies _____ Number of live births _____ Number of vaginal deliveries _____

Are you currently pregnant?	☐ Yes	☐ No
Are you currently breastfeeding?	☐ Yes	☐ No
Have you undergone menopause?	☐ Yes	☐ No
If so, at what age?	_____	
If not, when was your last period?	_____	

Reviewed by MD & discussed with patient _____

FAMILY HISTORY			
Please answer the following questions about your family members:			
Father	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Mother	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Siblings	# of brothers _____ # of sisters _____		
	Please list their medical problems (if any):		
Children	# of sons _____ # of daughters _____ Please list their medical problems (if any):		
Other	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)		
Has any family member had any disorder of the kidneys, bladder, or other part of the urinary tract? ☐ Yes ☐ No If yes, please describe:			

SOCIAL HISTORY		
Personal	Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
	Religious affiliation, if any?	Primary language?
Alcohol	Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week?	
	☐ Beer ☐ Wine ☐ Liquor	
Tobacco	Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?	
	What year did you start?	What year did you quit?
Drugs	Do you currently use recreational drugs? ☐ Yes ☐ No Have you in the past? ☐ Yes ☐ No	
	If yes, what kind?	
	Have you ever used intravenous drugs? ☐ Yes ☐ No	
Employment	Employment status: ☐ Employed ☐ Unemployed ☐ Retired	
	Occupation (past or present):	
Miscellaneous	Have you ever received a blood transfusion? ☐ Yes ☐ No	

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REVIEW OF SYSTEMS

Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:

Constitutional
- Fever ☐ Yes ☐ No
- Headache ☐ Yes ☐ No
- Unexplained weight loss ☐ Yes ☐ No
- Other: _____

Neurologic
- Numbness ☐ Yes ☐ No
- Tingling ☐ Yes ☐ No
- Weakness ☐ Yes ☐ No
- Dizziness ☐ Yes ☐ No
- Memory loss ☐ Yes ☐ No
- Seizures ☐ Yes ☐ No
- Other: _____

Respiratory
- Shortness of breath ☐ Yes ☐ No
- Wheezing ☐ Yes ☐ No
- Cough ☐ Yes ☐ No
- Other: _____

Cardiovascular
- Chest pain ☐ Yes ☐ No
- Irregular pulse ☐ Yes ☐ No
- Other: _____

Gastrointestinal
- Abdominal pain ☐ Yes ☐ No
- Nausea/vomiting ☐ Yes ☐ No
- Indigestion/heartburn ☐ Yes ☐ No
- Diarrhea ☐ Yes ☐ No
- Constipation ☐ Yes ☐ No
- Other: _____

Eyes
- Blurred vision ☐ Yes ☐ No
- Glaucoma ☐ Yes ☐ No
- Other: _____

Ear/Nose/Throat/Mouth
- Runny nose ☐ Yes ☐ No
- Difficulty hearing ☐ Yes ☐ No
- Other: _____

Endocrine
- Excessive thirst ☐ Yes ☐ No
- Too hot ☐ Yes ☐ No
- Too cold ☐ Yes ☐ No
- Other: _____

Allergic/Immunologic
- Hay fever ☐ Yes ☐ No
- Food allergies ☐ Yes ☐ No
- Other: _____

Musculoskeletal
- Joint pain ☐ Yes ☐ No
- Back pain ☐ Yes ☐ No
- Artificial joints ☐ Yes ☐ No
- Other: _____

Hematologic/Lymphatic
- Easy bruising or bleeding ☐ Yes ☐ No
- Blood clots in arms or legs ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Other: _____

Psychologic
- Anxiety ☐ Yes ☐ No
- Depression ☐ Yes ☐ No
- Other: _____

Integumentary
- Rash ☐ Yes ☐ No
- Boils/infections ☐ Yes ☐ No
- Other: _____

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