PATIENT MEDICAL HISTORY

UroGynecology SPECIALTY CENTER

PAST SURGICAL HISTORY

Hysterectomy: Year: _____

☐ Abdominal ☐ Vaginal ☐ Laparoscopic

☐ Robotic

Removal of Ovaries: ☐ Left ☐ Right ☐ Both

Heart Surgery:

Year: _____ Type: _____

Appendectomy:

Year: _____ Type: _____

Gall Bladder:

Year: _____ Type: _____

Bladder Surgery:

Year: _____ Type: _____

Rectal Surgery:

Year: _____ Type: _____

Other Surgery: _____

_____

_____

Patient Name: _____

DOB: _____

Date of service: _____

PAST OBSTECTRICAL/GYNOCOLOGIC HISTORY

Who is your OB/GYN? _____

When was your last pap smear? _____

Was it normal? Yes No

When was your last mammogram? _____

Was it normal? Yes No

Last gynecological exam: _____

Was it normal? Yes No

Date of menopause: _____

Number of pregnancies: _____

Number of deliveries: _____

Number of vaginal: _____

Number of C-sections: _____

SOCIAL HISOTRY

Tobacco use: ☐ Yes ☐ No # of years _____

If yes, amount (packs per day): _____

Alcohol use:

☐ Yes ☐ No _____

Drug use: ☐ Yes ☐ No _____

Caffeine use: ☐ Yes ☐ No _____

CURRENT MEDICATIONS/ALLERGIES

List all current medications: _____

_____

_____

_____

_____

ALLLERGIES: ☐ No ☐ Yes: _____

_____

_____

_____

_____

Urinary Symptoms

Are you experiencing any of the following urinary symptoms?

Dysuria (painful urination) ☐ Yes ☐ No

Urinary frequency ☐ Yes ☐ No If yes, how many times per day? _____

Urgency ☐ Yes ☐ No

Nocturia (waking up to urinate) ☐ Yes ☐ No If yes, how many times per night? _____

Post void fullness (feeling the need to urinate further after urinating) ☐ Yes ☐ No