

Urology New Patient (Female)

 Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last
Reason for your visit today? Be precise.
Physician that referred you for care at John Muir Urology: _____

PAST MEDICAL HISTORY

Do you have or have you had any of the following conditions?	YES	NO	Type / Year Diagnosed
Cancer (kidney, bladder)	<input type="checkbox"/>	<input type="checkbox"/>	
Heart (chest pain, heart attack, murmur)	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had an EKG?	<input type="checkbox"/>	<input type="checkbox"/>	When/Where?
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	
Blood or clotting problems	<input type="checkbox"/>	<input type="checkbox"/>	
Breast- cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach/Liver (reflux, bleeding, hepatitis, etc)	<input type="checkbox"/>	<input type="checkbox"/>	
Bowels (change in bowel habits, constipation, diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	
Glands (Diabetes, thyroid, gout)	<input type="checkbox"/>	<input type="checkbox"/>	
Gynecologic System (female organs)	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal (arthritis, disc disease)	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes/Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs (Asthma, Emphysema, Pneumonia, shortness of breath, TB)	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Brain/Nervous System (seizure, "blackout spells")	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Illness (Nervous condition/Depression)	<input type="checkbox"/>	<input type="checkbox"/>	
Skin (rash, psoriasis, hives)	<input type="checkbox"/>	<input type="checkbox"/>	
Constitutional (unexplained weight loss, fevers, chills, night sweats)	<input type="checkbox"/>	<input type="checkbox"/>	
Any other illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any accidents/injuries within the last 24 months?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever received the Shingles Vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	

PAST SURGICAL HISTORY

Type of Operation	Surgeon	Date(s)
Do you have any artificial joints and/or heart valves? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give which & date:	
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?	

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Names of <i>ALL</i> Physicians			
Name	Phone	Address	Specialty

GYNECOLOGICAL HISTORY		YES	NO	
Is there any chance you could be pregnant?		<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever taken birth control pills?		<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever taken hormone replacement therapy?		<input type="checkbox"/>	<input type="checkbox"/>	If yes, when:
Do you have a family history of breast cancer?		<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a hysterectomy?		<input type="checkbox"/>	<input type="checkbox"/>	If yes, What type? <input type="checkbox"/> Vaginal or <input type="checkbox"/> Abdominal
				If yes, Reason:
If yes, were tubes and ovaries removed?		<input type="checkbox"/>	<input type="checkbox"/>	
Are you sexually active?		<input type="checkbox"/>	<input type="checkbox"/>	
Do you frequently have pain with intercourse?		<input type="checkbox"/>	<input type="checkbox"/>	
Number of pregnancies		Number of live births		Number of Cesarean Sections
Age at first pregnancy		Did you breastfeed?		Date of last mammogram
Date of last pap smear		Onset of menstruation (age)		Age at menopause
Date of last menstrual period				

FAMILY HISTORY			
RELATION	AGE(S)	STATE OF HEALTH	IF DECEASED, CAUSE/AGE OF DEATH
Mother			
Father			
Siblings			
Spouse			
Children			

Are you of Ashkenazi Jewish descent?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Please list any diseases that run in your family, such as cancer, kidney stones, diabetes, etc.			
Disease		Family member	

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REVIEW OF SYSTEMS					
Have you experienced any of these problems during the past month?					
	YES	NO		YES	NO
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Mood changes or Depression	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Skin rash or itching	<input type="checkbox"/>	<input type="checkbox"/>	Frequent indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Loss of balance or coordination	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea or constipation	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Vision trouble	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contacts or glasses?	<input type="checkbox"/>	<input type="checkbox"/>	Foul-smelling urine	<input type="checkbox"/>	<input type="checkbox"/>
Arm or leg weakness	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Sinus drainage	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>			
Hoarseness or change in voice	<input type="checkbox"/>	<input type="checkbox"/>			
Sores in mouth or lip	<input type="checkbox"/>	<input type="checkbox"/>			
Cough	<input type="checkbox"/>	<input type="checkbox"/>			
Coughed up or spit up blood	<input type="checkbox"/>	<input type="checkbox"/>			
URINARY SYMPTOMS					
Check appropriate box:				<input type="checkbox"/>	<input type="checkbox"/>
Burning with urination				<input type="checkbox"/>	<input type="checkbox"/>
Urinating frequent, small amounts				<input type="checkbox"/>	<input type="checkbox"/>
Feeling like you need to urinate urgently! "or else....."				<input type="checkbox"/>	<input type="checkbox"/>
Lower abdominal pressure				<input type="checkbox"/>	<input type="checkbox"/>
Do you awaken at night to urinate?				<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times? _____				<input type="checkbox"/>	<input type="checkbox"/>
Do you pass air or "gas" in the urine?				<input type="checkbox"/>	<input type="checkbox"/>
URINARY TRACT INFECTIONS				YES	NO
1. Have you ever had any previous urinary infections (cystitis)? If NO, go on to question 6.				<input type="checkbox"/>	<input type="checkbox"/>
a) How many? _____					
b) Last infection _____					
c) At what age did they start? _____					
d) Related to sexual activity? _____				<input type="checkbox"/>	<input type="checkbox"/>
2. Did you ever have a high fever (102) with a urinary infection?				<input type="checkbox"/>	<input type="checkbox"/>
3. Did you ever have pain in the flank or kidneys with urinary infection?				<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had X-rays of the kidneys (IVP) or bladder (Voiding Cystogram)?				<input type="checkbox"/>	<input type="checkbox"/>
5. Were you ever hospitalized to treat a urinary infection?				<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a sexually transmitted disease?				<input type="checkbox"/>	<input type="checkbox"/>
Check: <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes <input type="checkbox"/> Genital Warts <input type="checkbox"/> PID <input type="checkbox"/> Other _____					
INCONTINENCE				YES	NO
Do you have leakage of urine (wetting of pants) with:					
a) Sneezing, coughing, straining				<input type="checkbox"/>	<input type="checkbox"/>
b) Laughing, walking				<input type="checkbox"/>	<input type="checkbox"/>
c) Upon arising from a sitting position				<input type="checkbox"/>	<input type="checkbox"/>
d) Sudden urge to urinate/cannot hold it until you get to the bathroom				<input type="checkbox"/>	<input type="checkbox"/>
e) During sexual intercourse				<input type="checkbox"/>	<input type="checkbox"/>
Do you use any pads for protection?				<input type="checkbox"/>	<input type="checkbox"/>
How many per day? _____					
Do you have to push or strain to empty the bladder?				<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a bladder suspension surgery?				<input type="checkbox"/>	<input type="checkbox"/>
If YES, through the Abdomen? <input type="checkbox"/> Through the Vagina? <input type="checkbox"/>					

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KIDNEY STONES		YES	NO
1. Do you have pain in the flank or kidney area?		<input type="checkbox"/>	<input type="checkbox"/>
If YES: <input type="checkbox"/> Left <input type="checkbox"/> Right			
2. Have you ever had a kidney stone?		<input type="checkbox"/>	<input type="checkbox"/>
3. If NO, skip to next section			
If YES,			
a) Date(s)? _____			
b) How many? _____			
c) Passed spontaneously? <input type="checkbox"/> YES <input type="checkbox"/> NO			
d) How was the stone removed? <input type="checkbox"/> Surgically <input type="checkbox"/> Basket			
e) Lithotripsy (shock waves)? <input type="checkbox"/> YES <input type="checkbox"/> NO			
4. What was the stone made of? <input type="checkbox"/> Calcium <input type="checkbox"/> Uric Acid <input type="checkbox"/> Other: _____			
5. Were you placed on stone prevention therapy?		<input type="checkbox"/>	<input type="checkbox"/>
6. What type? _____			
HEMATURIA		YES	NO
1. Have you seen blood in your urine?		<input type="checkbox"/>	<input type="checkbox"/>
2. If NO, skip to question 5			
If YES,			
a) Was the blood only at the beginning of the stream?		<input type="checkbox"/>	<input type="checkbox"/>
b) Throughout the stream?		<input type="checkbox"/>	<input type="checkbox"/>
c) At the end of the stream?		<input type="checkbox"/>	<input type="checkbox"/>
3. Was the bloody urine (check all that apply)			
<input type="checkbox"/> Tea colored			
<input type="checkbox"/> Rose wine/ cranberry colored			
<input type="checkbox"/> Burgundy wine colored			
<input type="checkbox"/> Clots			
4. Was there any pain or burning with the bloody urine?		<input type="checkbox"/>	<input type="checkbox"/>
5. Has a doctor found blood in your urine under a microscope?		<input type="checkbox"/>	<input type="checkbox"/>
SOCIAL HISTORY			
(✓)	SUBSTANCE:	APPROXIMATE YEAR STARTED / FREQUENCY:	
<input type="checkbox"/>	ALCOHOL	Year: <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Occasional/Social <input type="checkbox"/> Drinks/Day: _____	
<input type="checkbox"/>	SMOKING STATUS	<input type="checkbox"/> Current/Every Day <input type="checkbox"/> Current/Some Days <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoker <input type="checkbox"/> Unknown	
<input type="checkbox"/>	TOBACCO	Year: _____ Pack(s) A Day: _____ Quit: <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, Date Quit: _____	
<input type="checkbox"/>	STREET DRUGS/OTHER	Year: _____ Type: _____ Do you use needles?	
<input type="checkbox"/>	HIV positive or AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO	

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CURRENT MEDICATION LIST			
DRUG NAME	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

ALLERGIES

No Known Allergies Penicillin Codeine Sulfa Cipro Macrobid

MEDICATION	SPECIFIC TYPE OF REACTION

CONSENT TO ACCESS MEDICATION HISTORY

In order to provide you with the best possible care, your prescriptions will be written electronically whenever possible. Electronic prescribing is now a common practice due to healthcare initiatives requiring the use of electronic medical records. With your permission, e-prescribing will provide us access your medication history electronically, enabling us to see critically important information on your current and past prescriptions, better assess potential medication issues, and improve safety and quality of care.

By signing below I give my consent to John Muir Health to access my medication history electronically and to the best of my knowledge, I verify that the above medical information is complete and correct. I understand that it is my responsibility to inform my physician if I ever have a change in my health.

*** SIGNATURE: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

PREFERRED OUTSIDE PHARMACY

Name & Address (Location) of Preferred OUTSIDE Pharmacy: Is this is a MAIL ORDER PHARMACY? Yes No

Please list a local pharmacy for urgent prescriptions if primary is a mail order.

Name & Address of LOCAL pharmacy:

Urogynecology New Patient Questionnaire

Genitourinary Symptoms

1. On average, I get up to urinate every ____ hours during the day.
2. On average, I get up ____ times during the night to urinate.
3. When I get the urge to void it comes on suddenly: Yes/No (circle one)
4. Urge incontinence: I will leak urine due to a sudden urge to urinate approximately ____ times per DAY/WEEK (circle one); ____ Just drops ____ Large volume
5. Stress urinary incontinence: I will leak urine due to cough/sneeze/laugh/activity approximately ____ times per DAY/WEEK (circle one)
6. I wear incontinence pads for leakage. I will go through ____ pads during the day.
7. I wear a thin pantiliner for leakage. I will go through ____ liners during the day.
8. My stream is mostly: (circle one) Brisk / Normal / Weak / Dribbles
9. Incomplete emptying: When I am done urinating, I feel that my bladder is empty: Yes/No (circle one).
10. Splinting: I have to use my fingers and push around my vagina in order to help empty my bladder. Yes/No (circle one).
11. Strain: I strain or push to empty my bladder. Yes/No (circle one).
12. Dysuria: I have pain when emptying my bladder. Yes/No (circle one).
13. Number of urinary tract infections in last 12 months: ____ . In the last 6 months ____.
14. I have seen blood in my urine: Yes/No (circle one).
15. I have been told there is blood in my urine: Yes/No (circle one)
16. History of stones: Yes/No (circle one). Last stone: ____ (date). Treatment: _____.
17. I drink ____ glasses (8 oz) of WATER per day.
18. I also drink the following DAILY [] Coffee # ____ cups. [] Black or green Tea # ____ cups. [] Soda # ____ cans. [] Citrus drinks # ____ cups. [] Alcohol # ____ glasses.
19. On a scale of 1-10 (1 = no bother; 10 = horrible), my urinary symptoms bother me to a level of: ____/10.

Pelvic Organ Prolapse Symptoms

1. I can feel or see a vaginal bulge: Yes/No (circle one). Since _____ (Date).
2. I have to use my finger and apply pressure in order to have a bowel movement: Yes/No (circle one)
3. I have been evaluated for the vaginal bulge before: Yes/No (circle one)
 - a. I have tried _____.
4. On a scale of 1-10, my vaginal bulge symptoms bother me to a level of: ____/10.

Sexual Health symptoms

1. I am sexually active: Yes/No (circle one).
2. My partner is/was: Male/Female (circle one).
3. My intercourse involves(ed) vaginal penetration: Yes/No (circle one).
4. My last intercourse was: _____ (approximate date).
5. My frequency of intercourse is approx.. ____ times every ____ weeks/months.
6. I feel pain with intercourse: Yes/No (circle one).
7. My partner feels pain with intercourse: Yes/No (circle one).
8. My vagina feels dry: Yes/No (circle one).
9. I use hormone replacement therapy: Yes/No (circle one). Type: _____.
10. I use low-dose vaginal estrogen cream: Yes/No (circle one). Type: _____.

Colorectal symptoms

1. I make a bowel movement: _____ times every _____ day(s).
2. The consistency of my stool is:
 - a. Mostly diarrhea (watery)
 - b. Mostly soft but formed
 - c. Mostly hard but formed
 - d. Very hard (small, hard, constipated)
 - e. Perfect (not too loose or too hard)
3. I use of stool softeners/laxatives/fiber to help me pass stool: _____.
4. I have had stool accidents. Yes/No (circle one).

Obstetrical History

Number of live births: _____.

Birth #	Year	Normal or Cesarean	Birth weight (lbs)	Complications	Status

Gynecologic History

Year	Surgeon	Surgery (i.e. hysterectomy, prolapse repair)	Route (vaginal laparoscopic or abdominal)	Reason for hysterectomy (bleeding, fibroids, cancer, etc)	Status of ovaries (removed or still have)

Last PAP Smear: _____ (date). Normal or abnormal (circle one).
 Breast Cancer history: N/A or Year _____. Treatment: _____.

PRE-MENOPAUSAL WOMEN:

1. I menstruate and my cycles are: Regular/Irregular (circle one). Every _____ days.
2. Contraception/type: _____. Since (date)_____.

POST-MENOPAUSAL WOMEN:

1. Approximate age at menopause: _____.
2. Since going through menopause or hysterectomy, I have had vaginal bleeding: Yes/No

Social Hx:

Occupation: _____ . Active or Retired.

Other occupants in your place of living: _____.

Do you feel safe in your home? Yes/No.