Female Questionnaire-------*ANSWER ALL QUESTIONS THAT YOU CAN on Pages 1-3, Name and Date on every page*

What is your reason for seeing the doctor?

(Please Circle) **Notes On Present Illness:**

[Yes]	[No]	Have You Been Seen Previously In This Office?
[Yes]	[No]	Pain or burning with urination?
[Yes]	[No]	Blood in urine at any time?
[Yes]	[No]	Slow urinary stream?
[Yes]	[No]	Difficulty starting urination?
[Yes]	[No]	Incontinence or inability to hold urine (wet pants)?
[Yes]	[No]	Urinating too frequently (more than 6 times a day)?
[Yes]	[No]	Awakening at night to urinate more than once?
[Yes]	[No]	Bedwetting?
[Yes]	[No]	Urinary tract infection [Kidney] [Bladder]
[Yes]	[No]	Kidney stone?
[Yes]	[No]	Recent fevers or chills?
[Yes]	[No]	Have you been to a urologist before?
[Yes]	[No]	Have you had kidney or bladder x-rays before?
[Yes]	[No]	Are your periods normal? If not describe…..
[Yes]	[No]	Recent vaginal discharge
[Yes]	[No]	Use of birth control pills/hormones [Now] [In past]

----------Do not write in enclosed space----------

HPI

Location
Quality
Severity + ++ +++ ++++
Duration
Timing
Content
Modifying factors
Associated signs and sxs

Name_____ Date _____

CONTINUE ON TO THE NEXT PAGE →

Please fill in all drugs or medications that you are **allergic to or cannot tolerate**

Allergies	(list all allergies)				

Please fill in **ALL drugs, medications, or pills** that you are currently taking

Date	**Drug Name**	**Dosage**	**Refill Date**	**Refill Date**	**Refill Date**

Name_____ Date _____ *CONTINUE ON TO THE NEXT PAGE →*

Do you take aspirin or any aspirin-containing drugs [Yes] [No]
Do you take over the counter medications [Yes] [No] If yes, list on drug page #2

List **all** previous operations or surgeries

_____ _____ _____ _____

List **all** previous serious illnesses or injuries

_____ _____ _____ _____

Has anyone in your family had any hereditary disease [yes] [no]

Do you smoke cigarettes? [Yes] [No] If yes, how many packs per day?_____
If you have stopped, when did you stop?_____

Do you drink alcoholic beverages? [never] [occasional] [moderate] [heavy]

Occupation_____ [retired] Hobbies/FreeTime_____

Have you had problems with . . .? (circle if [Yes])

[Yes]	[No]	Eyes/Ears	[Yes]	[No]	Arthritis
[Yes]	[No]	Mouth/Throat	[Yes]	[No]	Joint problems
[Yes]	[No]	Heart attack	[Yes]	[No]	Back problems
[Yes]	[No]	Heart murmur	[Yes]	[No]	Anemia
[Yes]	[No]	Irregular heart rhythm	[Yes]	[No]	Bleeding tendency
[Yes]	[No]	Chest pain	[Yes]	[No]	Psychiatric problems
[Yes]	[No]	High blood pressure	[Yes]	[No]	Depression
[Yes]	[No]	Shortness of breath	[Yes]	[No]	Seizure/epilepsy
[Yes]	[No]	Cough	[Yes]	[No]	Stroke
[Yes]	[No]	Asthma	[Yes]	[No]	Headache
[Yes]	[No]	Stomach pain	[Yes]	[No]	Weight loss or gain
[Yes]	[No]	Ulcer	[Yes]	[No]	Chronic pain
[Yes]	[No]	Diarrhea	[Yes]	[No]	Sweats
[Yes]	[No]	Constipation	[Yes]	[No]	Diabetes
[Yes]	[No]	Blood in stool	[Yes]	[No]	Thyroid problems
[Yes]	[No]	Skin problems	[Yes]	[No]	Breast Problems

How many pregnancies?_____ How many children born alive _____
When was your last PAP smear?_____ Last Mammogram _____

ARE THERE ANY OTHER PROBLEMS THAT HAVE NOT BEEN MENTIONED?

Name_____ Date _____