WILMINGTON HEALTH

Female Urology Intake Form

Name:_____Date of birth:_____Age:_____
Main reason for visit:_____
Referred by (name of MD):_____
Additional details concerning visit:_____

Medical Issues:

_____
_____
_____

Past Surgeries and Date:

_____
_____
_____

Medication & Dosage:

_____
_____
_____
_____

Medication & Dosage:

_____
_____
_____
_____

Do you smoke: Yes☐ No☐ Packs per day?____When did you quit?_____
Do you drink alcohol?__☐__Yes__☐__No

Family History (Check if applicable)

Bladder Cancer__☐__ Kidney Cancer_____☐_____ Kidney Stones___☐____ Prostate Cancer____☐____

Circle all that apply to you:

Chills Fever Fatigue Hearing Loss Visual Changes Cough Shortness of Breath
Wheezing Chest Pain Leg Swelling Palpitations Abdominal Pain Constipation Nausea
Vomiting Headaches Frequent Dizziness Seizures Tremors Anxiety Depression Cold Intolerance Heath Intolerance
Back Pain Joint Pain Muscle Weakness Neck Pain Easy Bleeding Easy Bruising Recent Abnormal Pap Smear Pain with Intercourse Vaginal Discharge Itchy Skin Rash Skin Lesion

Other symptoms:_____
Preferred Pharmacy and address:_____

Urination Questions:

Do you leak urine? (check all that apply)___☐ When you can't make it to restroom? ___☐ When you cough, sneeze or laugh?
How many pads do you wear per day?_____(circle one) Liner Pad Diaper
How often do you urinate? (circle) Every: 15-20 min 1-2 hours 3-4 hours Other_____
Do you urinate with a sense of urgency? __☐__Yes __☐__No
How many caffeinated drinks do you have per day?_____
Total fluid intake (select one): Light___☐___ Moderate___☐___ Heavy____☐____
Do you feel you can empty your bladder completely?___☐___Yes ___☐___No
Do you feel a vaginal bulge?☐Yes ☐No Are you sexually active:___☐__Yes ___☐__No
Are you bothered by vaginal dryness? ☐Yes ☐No History of pelvic surgery? Yes☐No☐
Type of surgery_____ Mesh?_____Surgery on bladder or vagina? Yes☐ No☐
If yes, name of surgeon, where surgery was done and date of surgery_____
Number of time you have been pregnant?____ Number of deliveries: Vaginal_____C-Section_____
Did you have your uterus removed? Yes☐No☐ If yes, reason and year_____
History of abnormal pap smears? Yes☐ No☐ Unexpected vaginal bleeding? Yes☐ No☐
Unexpected vaginal bleeding? Yes__☐__ No__☐__
Frequent urinary tract infections? Yes☐ No☐
Number of urinary tract infections in last 1 yr☐ 5yrs☐ Organism_____ Antibiotic_____
Have you seen any blood in the urine? Yes___☐___ No__☐__

Constipation & Management

Do you have difficulty with constipation? Yes__☐__ No__☐__ Medication for constipation_____
Do you leak stool? Yes__☐__ No___☐___ If yes, are you seeing GI or Colorectal Surgeon for this?_____