



# Female Intake Form

Revised: 11/13/2025  
WH Urology  
1202 Medical Center Dr.  
Wilmington, NC 28401

## Female Urology Intake Form

### Patient Information

- Name: \_\_\_\_\_
- DOB: \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_
- Main reason for today's visit: \_\_\_\_\_
- Referred by (Physician): \_\_\_\_\_
- Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### Urinary Symptoms-Do you have/do any of the following:

- Leakage:  Can't reach bathroom  With cough/sneeze/laugh
- Number of Pads per day: \_\_\_\_\_ Type of Pads you use:  Liner  Pad  Diaper
- Nighttime urination: \_\_\_\_\_ times/night
- Frequency: (circle one): 15-30 min 1-2 hrs. 3-4 hrs. Other: \_\_\_\_\_
- Strain to urinate:  Yes  No
- Empty bladder completely:  Yes  No
- Past bladder meds:  Yes  No If yes, list: \_\_\_\_\_
- How many caffeinated drinks/days: \_\_\_\_\_
- Fluid intake:  Light  Moderate  Heavy

### Pelvic & Sexual Health-Do you have any of the following:

- Vaginal bulge:  Yes  No
- Abdominal/pelvic surgery:  Yes  No Type: \_\_\_\_\_
- Are you sexually active:  Yes  No
- Pain with intercourse:  Yes  No
- Vaginal dryness:  Yes  No
- Using vaginal estrogen:  Yes  No If yes, what type: \_\_\_\_\_

### Obstetric History

- Number of Pregnancies: \_\_\_ Number of Deliveries: \_\_\_ Type:  Vaginal  C-section
- Tear at delivery:  Yes  No
- Largest baby weight: \_\_\_\_\_ lb. \_\_\_\_\_ oz
- Did you have your uterus removed:  Yes  No
- Have you had any unexpected bleeding:  Yes  No

### Infection & Blood in Urine

- Frequent UTIs:  Yes  No Number in past year: \_\_\_\_\_ Blood in urine:  Yes  No Workup done with another urologist:  Yes  No



# Female Intake Form

Revised: 11/13/2025  
WH Urology  
1202 Medical Center Dr.  
Wilmington, NC 28401

## Bowel Health

- Constipation:  Yes  No- **Circle One**-Daily/ Often/Occasionally
- Meds/Bowel regimen: \_\_\_\_\_
- Leak stool:  Yes  No- **Circle One**-Daily/ Often/Occasionally
- Have you seen GI/colorectal surgeon:  Yes  No If yes whom \_\_\_\_\_

## Care Providers & Pharmacy

- Previous Urologist: \_\_\_\_\_
- Pharmacy: \_\_\_\_\_

## Medical History

- Medical Conditions: \_\_\_\_\_  
\_\_\_\_\_
- Past Surgeries & Dates: \_\_\_\_\_  
\_\_\_\_\_
- Current Medications: \_\_\_\_\_  
\_\_\_\_\_
- Allergies: \_\_\_\_\_

## Lifestyle History

- Do you smoke:  Yes  No If yes, packs/day: \_\_\_\_\_ If quit, when: \_\_\_\_\_
- Do you drink alcohol:  Yes  No If so, how much per day/week/monthly: \_\_\_\_\_

## Family History (check all that apply)

- Bladder Cancer-Whom \_\_\_\_\_
- Prostate Cancer-Whom \_\_\_\_\_
- Kidney Cancer-Whom \_\_\_\_\_
- Kidney Stones-Whom \_\_\_\_\_