JOHN MUIR HEALTH

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**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) | ❑ | ❑ | |
| Heart (chest pain, heart attack, murmur) | ❑ | ❑ | |
| Have you had an EKG? | ❑ | ❑ | When/Where? |
| High Blood Pressure | ❑ | ❑ | |
| Pacemaker | ❑ | ❑ | |
| Blood or clotting problems | ❑ | ❑ | |
| Breast- cancer | ❑ | ❑ | |
| Stomach/Liver (reflux, bleeding, hepatitis, etc) | ❑ | ❑ | |
| Bowels (change in bowel habits, constipation, diarrhea) | ❑ | ❑ | |
| Glands (Diabetes, thyroid, gout) | ❑ | ❑ | |
| Gynecologic System (female organs) | ❑ | ❑ | |
| Musculoskeletal (arthritis, disc disease) | ❑ | ❑ | |
| Eyes/Ears/Nose/Throat | ❑ | ❑ | |
| Stroke | ❑ | ❑ | |
| Lungs (Asthma, Emphysema, Pneumonia, shortness of breath, TB) | ❑ | ❑ | |
| Bladder Disease | ❑ | ❑ | |
| Brain/Nervous System (seizure, "blackout spells") | ❑ | ❑ | |
| Mental Illness (Nervous condition/Depression) | ❑ | ❑ | |
| Skin (rash, psoriasis, hives) | ❑ | ❑ | |
| Constitutional (unexplained weight loss, fevers, chills, night sweats) | ❑ | ❑ | |
| Any other illnesses? | ❑ | ❑ | |
| Have you had any accidents/injuries within the last 24 months? | ❑ | ❑ | |
| Have you ever received the Shingles Vaccine? | ❑ | ❑ | |

## PAST SURGICAL HISTORY

| Type of Operation | Surgeon | Date(s) |
|---|---|---|
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|---|---|
| Do you have any artificial joints and/or heart valves? ❑ Yes ❑ No | If yes, give which & date: |
| Have you ever had a blood transfusion? ❑ Yes ❑ No | If yes, when? |

Patient Name: _____ Date of Birth: _____ Today's Date: _____
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| Names of ***ALL*** Physicians | | | |
|---|---|---|---|
| **Name** | **Phone** | **Address** | **Specialty** |
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| **GYNECOLOGICAL HISTORY** | **YES** | **NO** | |
|---|---|---|---|
| Is there any chance you could be pregnant? | ❑ | ❑ | |
| Have you ever taken birth control pills? | ❑ | ❑ | |
| Have you ever taken hormone replacement therapy? | ❑ | ❑ | If yes, when: |
| Do you have a family history of breast cancer? | ❑ | ❑ | |
| Have you had a hysterectomy? | ❑ | ❑ | If yes, What type? ❑ Vaginal or ❑ Abdominal |
| | | | If yes, Reason: |
| If yes, were tubes and ovaries removed? | ❑ | ❑ | |
| Are you sexually active? | ❑ | ❑ | |
| Do you frequently have pain with intercourse? | ❑ | ❑ | |

| | | | | | |
|---|---|---|---|---|---|
| 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** ❑ | **NO** ❑ | |

| Please list any diseases that run in your family, such as cancer, kidney stones, diabetes, etc. | |
|---|---|
| Disease | Family member |
| | |
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Patient Name: _____ Date of Birth: _____ Today's Date: _____
*First Middle Initial Last*

## REVIEW OF SYSTEMS

Have you experienced any of these problems during the past month?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Weight loss | ❑ | ❑ | Chest Pain/Palpitations | ❑ | ❑ |
| Fevers | ❑ | ❑ | Mood changes or Depression | ❑ | ❑ |
| Chills | ❑ | ❑ | Trouble sleeping | ❑ | ❑ |
| Skin rash or itching | ❑ | ❑ | Frequent indigestion | ❑ | ❑ |
| Headaches | ❑ | ❑ | Nausea or vomiting | ❑ | ❑ |
| Loss of balance or coordination | ❑ | ❑ | Diarrhea or constipation | ❑ | ❑ |
| Hearing loss | ❑ | ❑ | Jaundice | ❑ | ❑ |
| Vision trouble | ❑ | ❑ | Rectal bleeding | ❑ | ❑ |
| Do you wear contacts or glasses? | ❑ | ❑ | Foul-smelling urine | ❑ | ❑ |
| Arm or leg weakness | ❑ | ❑ | Blood in urine | ❑ | ❑ |
| Sinus drainage | ❑ | ❑ | | | |
| Difficulty swallowing | ❑ | ❑ | | | |
| Hoarseness or change in voice | ❑ | ❑ | | | |
| Sores in mouth or lip | ❑ | ❑ | | | |
| Cough | ❑ | ❑ | | | |
| Coughed up or spit up blood | ❑ | ❑ | | | |

| URINARY SYMPTOMS | YES | NO |
|---|---|---|
| ***Check appropriate box:*** | ❑ | ❑ |
| Burning with urination | ❑ | ❑ |
| Urinating frequent, small amounts | ❑ | ❑ |
| Feeling like you need to urinate urgently! "or else….." | ❑ | ❑ |
| Lower abdominal pressure | ❑ | ❑ |
| Do you awaken at night to urinate? | ❑ | ❑ |
| If yes, how many times? _____ | ❑ | ❑ |
| Do you pass air or "gas" in the urine? | ❑ | ❑ |

| URINARY TRACT INFECTIONS | YES | NO |
|---|---|---|
| 1. Have you ever had any previous urinary infections (cystitis)? **If NO, go on to question 6**. | ❑ | ❑ |
| a) How many? _____ | | |
| b) Last infection _____ | | |
| c) At what age did they start? _____ | | |
| d) Related to sexual activity? | ❑ | ❑ |
| 2. Did you ever have a high fever (102) with a urinary infection? | ❑ | ❑ |
| 3. Did you ever have pain in the flank or kidneys with urinary infection? | ❑ | ❑ |
| 4. Have you ever had X-rays of the kidneys (IVP) or bladder (Voiding Cystogram)? | ❑ | ❑ |
| 5. Were you ever hospitalized to treat a urinary infection? | ❑ | ❑ |
| 6. Have you ever had a sexually transmitted disease? | ❑ | ❑ |
| Check: ☐ Gonorrhea ☐ Chlamydia ☐ Herpes ☐ Genital Warts ☐ PID ☐ Other _____ | | |

| INCONTINENCE | YES | NO |
|---|---|---|
| Do you have leakage of urine (wetting of pants) with: | | |
| a) Sneezing, coughing, straining | ❑ | ❑ |
| b) Laughing, walking | ❑ | ❑ |
| c) Upon arising from a sitting position | ❑ | ❑ |
| d) Sudden urge to urinate/cannot hold it until you get to the bathroom | ❑ | ❑ |
| e) During sexual intercourse | ❑ | ❑ |
| Do you use any pads for protection? | ❑ | ❑ |
| How many per day? _____ | | |
| Do you have to push or strain to empty the bladder? | ❑ | ❑ |
| Have you ever had a bladder suspension surgery? | ❑ | ❑ |
| If YES, through the Abdomen? ❑ Through the Vagina? ❑ | | |

Patient Name: _____ Date of Birth: _____ Today's Date: _____
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| KIDNEY STONES | YES | NO |
|---|---|---|
| 1. Do you have pain in the flank or kidney area? | ❑ | ❑ |
| If YES: ❑ Left ❑ Right | | |
| 2. Have you ever had a kidney stone? | ❑ | ❑ |
| **3. If NO, skip to next section**<br>If YES,<br>a) Date(s)? _____<br>b) How many? _____<br>c) Passed spontaneously? ❑ YES ❑ NO<br>d) How was the stone removed? ❑ Surgically ❑ Basket<br>e) Lithotripsy (shock waves)? ❑ YES ❑ NO | | |
| 4. What was the stone made of? ❑ Calcium ❑ Uric Acid ❑ Other: _____ | | |
| 5. Were you placed on stone prevention therapy? | ❑ | ❑ |
| 6. What type? _____ | | |

| HEMATURIA | YES | NO |
|---|---|---|
| 1. Have you seen blood in your urine? | ❑ | ❑ |
| **2. If NO, skip to question 5**<br>If YES, | | |
| a) Was the blood only at the beginning of the stream? | ❑ | ❑ |
| b) Throughout the stream? | ❑ | ❑ |
| c) At the end of the stream? | ❑ | ❑ |
| 3. Was the bloody urine *(check all that apply)*<br>❑ Tea colored<br>❑ Rose wine/ cranberry colored<br>❑ Burgundy wine colored<br>❑ Clots | | |
| 4. Was there any pain or burning with the bloody urine? | ❑ | ❑ |
| 5. Has a doctor found blood in your urine under a microscope? | ❑ | ❑ |

## SOCIAL HISTORY

| (✓) | SUBSTANCE: | APPROXIMATE YEAR STARTED / FREQUENCY: |
|---|---|---|
| ❑ | ALCOHOL | Year: ☐ Never ☐ Rarely ☐ Occasional/Social ☐ Drinks/Day: _____ |
| ❑ | SMOKING STATUS | ❑ Current/Every Day ❑ Current/Some Days ❑ Former Smoker ❑ Never Smoker ❑ Unknown |
| ❑ | TOBACCO | Year: Pack(s) A Day: Quit: ☐ NO ☐ YES *If YES*, Date Quit: |
| ❑ | STREET DRUGS/OTHER | Year: Type: Do you use needles? |
| ❑ | HIV positive or AIDS | ☐ YES ☐ NO |

Patient Name: _____ Date of Birth: _____ Today's Date: _____
*First Middle Initial Last*

## CURRENT MEDICATION LIST

| DRUG NAME | DOSE | FREQUENCY | PRESCRIBING PHYSICIAN |
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## ALLERGIES

☐ **No Known Allergies** ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Cipro ☐ Macrobid

| MEDICATION | SPECIFIC TYPE OF REACTION |
|---|---|
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## 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 <u>OUTSIDE</u> 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 |
|---|---|---|---|---|---|
| | | | | | |
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***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.