TMH PHYSICIAN PARTNERS

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UROLOGY SPECIALISTS
NEW PATIENT MEDICAL HISTORY FORM (FEMALE)

Patient Name: ________________________________ Today's Date: _________________________

Date of Birth: ________________________ Age: ___________ Height: __________ Weight: _______

Reason for visit?____

Referring physician: __________________________ Primary Care Physician: __________________________

Please check any of the following health problems you have had or have now:

[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Stroke (or Mini-stroke)
[ ] Diabetes
[ ] Heart Disease
[ ] Kidney Stones
[ ] Kidney Infection
[ ] Shortness of Breath
[ ] Heart Murmur
[ ] Cancer
[ ] AIDS/HIV
[ ] Blood clotting problems

List Operations or Procedures and when?

Year	Surgery	Year	Surgery

Family History: Please check the following health problems that have affected your family and identify their relationship to you, ie: mother, father, grandparent, sibling.

[ ] Cervical Cancer_______________ [ ] Bladder Cancer ______________ [ ] Kidney Stones ______________

Urinary Complaints:

Do you experience urinary frequency during the day? [ ] No [ ]Yes If yes, how often? _____________

Do you wake up at night to urinate? [ ] No [ ]Yes If yes, how often? _____________

Have you ever seen blood in your urine? [ ] No [ ]Yes

Have you ever had a urinary tract infection? [ ] No [ ]Yes If yes, how often? _____________

Do you have to push or strain to begin urination? [ ] No [ ]Yes

Does your urinary stream stop and start? [ ] No [ ]Yes

Do you experience incomplete bladder emptying? [ ] No [ ]Yes

Do you have burning or discomfort with urination? [ ] No [ ]Yes

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Do you ever have the urge to rush to urinate? [ ] No [ ]Yes If yes when? _______________

Do you ever lose control or leak urine suddenly? [ ] No [ ]Yes

Do you ever leak urine when you cough, sneeze, or exercise? [ ] No [ ]Yes

Do you wear pads to collect urinary leakage? [ ] No [ ]Yes If yes, how many? ___________

Are you bothered by the way you urinate? [ ] No [ ]Yes

Do you have pain associated with your bladder or pelvic area (lower abdomen, vagina, urethra)? [ ] No [ ]Yes If yes, since when? __________

Your age at first menstrual period: ______ Date of last period: ______________

#of pregnancies ______ # of live births _____ Post menopausal? [ ] No [ ]Yes

Are you sexually active? [ ]No [ ]Yes

Any history of sexually transmitted disease (STD)? [ ]No [ ] Yes If yes, which STD? _____________

Do you drink coffee? [ ] No [ ] Yes; if yes, how many cups per day? ___________

Do you use tobacco products? [ ]No [ ]Yes; if yes, packs /day: _________Year Quit: __________

Do you drink alcohol? [ ]No [ ]Yes; if Yes, drinks per day _____ Per week: _______

Do you use recreational drugs? [ ]No [ ]Yes; if yes, describe: ____

Have you lost interest in doing things that use to give you pleasure?
[ ] Not at all, [ ] several days, [ ] more than half the days, [ ] nearly every day.

Have you been feeling down, depressed or hopeless in the past 2 weeks?
[ ] Not at all, [ ] several days, [ ] more than half the days, [ ] nearly every day.

Have you experienced 10 lbs weight loss or weight gain in the past 3 months? [ ] No [ ] Yes

Do you have problems with mobility (use a wheelchair, cane or walker)? [ ]No [ ] Yes; if yes, please describe the problem and/or the device used.____

Have you had a fall in the past year? [ ] No [ ] Yes

Do you feel unsteady? [ ] No [ ] Yes

Are you in a relationship where you are being threatened or hurt? [ ] No [ ] Yes

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Patient Name:____ **Date of Birth** :________________________

List Drug, Food, or Substance Allergies & Reactions:

____

____

____

Preferred Pharmacy:____________________________ **Pharmacy Location:**_________________________________

Complete your medication list to the best of your ability:

Date	Drug	Dose	Frequency	Indication

***Keep an updated medication list with you at all times in case of emergency situations. Update the information when medications are changed or discontinued. If you have been seen for a consult, give a copy of your medication list to your Primary Care Physician.

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Patient's Name: ____ Date of Birth: ______________Date Completed:____________

OVERACTIVE BLADDER SHORT FORM QUESTIONNAIRE

	Overactive Bladder Part A Circle the appropriate number	Not at all	A Little Bit	Some-what	Quite a Bit	A Great Deal	A Very Great Deal
1.	An uncomfortable **urge** to urinate?	1	2	3	4	5	6
2.	A sudden urge to urinate with **little or no warning?**	1	2	3	4	5	6
3.	**Accidental loss** of small amounts of urine?	1	2	3	4	5	6
4.	**Nighttime urination**?	1	2	3	4	5	6
5.	**Waking up at night** because you had to urinate?	1	2	3	4	5	6
6.	Urine loss associated with a **strong desire** to urinate?	1	2	3	4	5	6
TOTAL SCORE, PART A (Lowest=6, Highest = 36)							

	Overactive Bladder Part B Circle the appropriate number	Not at all	A Little Bit	Some-what	Quite a Bit	A Great Deal	A Very Great Deal
7.	Caused you to **plan "Escape Routes"** to restrooms in public places?	1	2	3	4	5	6
8.	Made you feel like there is **something wrong** with you?	1	2	3	4	5	6
9.	Interfered with your ability to get a good **night's rest?**	1	2	3	4	5	6
10.	Made you frustrated or annoyed about the amount of **time you spend in the restroom**?	1	2	3	4	5	6
11.	Made you **avoid activities** away from Restrooms (eg. sports, exercising)	1	2	3	4	5	6
12.	**Awakened** you during sleep?	1	2	3	4	5	6
13.	Caused you to **decrease your physical activity** (e.g. sports, exercising)	1	2	3	4	5	6
14.	Caused you to have **problems with your partner or spouse**?	1	2	3	4	5	6
15.	Made you uncomfortable with **traveling** with others because of needing to stop for a restroom?	1	2	3	4	5	6
16.	**Affected your relationships** with family and friends?	1	2	3	4	5	6
17.	Interfered with getting the **amount of sleep** you needed?	1	2	3	4	5	6
18.	Caused you **embarrassment**?	1	2	3	4	5	6
19.	Caused you to **locate the closest restroom** as soon as you arrive at a place you have never been?	1	2	3	4	5	6
TOTAL SCORE, PART B (Lowest = 13, Highest = 78)							