

UHMP Urology

NAME: _____ DATE: _____

FEMALE UROLOGIC HISTORY

Please Answer all Questions that you can
(circle each answer)

- 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 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 Kidney Infections
Yes No Bladder Infections
Yes No Kidney Stones
Yes No Tuberculosis
Yes No Recent fevers or chills
Yes No Have you been to Urologist before?
Yes No Have you had Kidney or Bladder X-Rays before?
Yes No Have you had prior surgery on the Bladder or Kidneys?
Yes No have you ever had any of the following sexually transmitted diseases? GC,
Chlamydia, HPV, HIV, Hepatitis, AIDS?
Yes No Are your menstrual cycles normal? If not, describe:

Yes No Recent Vaginal Discharge

Yes No Have you been on birth control pills? [Current] [In Past]

Yes No Have you had prior surgery on Uterus, Ovaries or Vagina?

If yes, Describe: _____

If applicable, When was your last menstrual cycle? _____

When was your last pap smear? _____

If applicable, What type of contraception are you using? _____

If applicable, How many times have you been pregnant? _____

How many babies have you delivered vaginally? _____

How many babies have you delivered by C-Section? _____

Yes No Are you Constipated?

Yes No Inability to control bowel movements?

Yes No Do you have any Difficulty with Sexual Function or
Achieving Orgasms?