

Medications:

Please list all medications you take, (including vitamins and non-prescription medicines), when and how much you take, and why you take them:

Medicine	Dosage / times per day	Reason

Do you take any medications that may affect your blood clotting? (e.g. coumadin aspirin Lovenox **pain medication** other than Tylenol)? None

Allergies:

Please list all medications to which you are allergic, and any reaction you may have had (nausea, hives, rash, told you were allergic since childhood etc.)

Medication	What happened?

Are you allergic to: x-ray dye iodine shellfish No allergies to any medication

Family History:

Relation	If living, current age	Medical Problems	Age and cause of death
Father			
Mother			
Siblings:			
Children:			

Social History:

Tobacco use: never used to still smoke I smoke(d) ___packs per day for ___years from age___until ___.

Alcoholic beverages: never occasionally every evening heavy drinker

Illegal drugs: yes no

Marital status: single married divorced widowed Number of children: _____

Employment status: employed retired unemployed student

Occupation: _____ Position: _____

Hobbies: _____

How many times have you been **pregnant**? _____

How many children have you had by **vaginal delivery**? _____ By **cesarean section**? _____
Were any of the deliveries especially difficult or prolonged? If so, please explain.

Are you still having menstrual periods? **Yes** **No**

Have you had a hysterectomy (removal of the uterus or womb)? **Yes** **No**

If yes, why was it done? **fibroids** **bleeding** **cancer** **incontinence**

Was it removed through the **abdomen** **vagina** ?

Were your ovaries removed at the same time? **Yes** **No** **Not sure**

Was an additional procedure done on your bladder? **Yes** **No** **Not sure**

Do you take any hormone replacements? **pills** **patch** **cream** **None**

Do you have trouble with urinary incontinence? **Yes** **No** **If no, skip to the last page**

Do you wear pads or panty liners for incontinence? **Yes** **No** If yes, how many pads or liners do you use on a typical day? _____

Do you leak when **coughing** **sneezing** **walking steps**, or with **exercise**?

Do you often feel the urge to urinate **without warning** or even when **your bladder is not full**?

Do you have **burning on urination** **pain when urinating**, or **incontinence while sleeping**?

Have you tried any type of treatment in the past for incontinence? **Yes** **No**
If yes, did it involve **medication** **exercises** **surgery**?

When was your **last mammogram**? _____ **Pap smear**? _____

Review of Systems

Please check off any of the items below that may have been a problem for you recently.

- | | | | |
|--|---|--|--|
| Constitutional | <input type="checkbox"/> chronic fever | <input type="checkbox"/> joint pain | <input type="checkbox"/> weight loss > 20 lb. |
| | <input type="checkbox"/> night sweats | <input type="checkbox"/> bone pain | recent severe pain |
| Eyes | <input type="checkbox"/> glaucoma | <input type="checkbox"/> blurry vision | <input type="checkbox"/> cataracts |
| | | | <input type="checkbox"/> double vision |
| Ear/Nose/Throat | <input type="checkbox"/> earaches | <input type="checkbox"/> dizziness | <input type="checkbox"/> chronic sore throat |
| | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> hoarseness |
| Cardiovascular | <input type="checkbox"/> heart attack | <input type="checkbox"/> heart failure | <input type="checkbox"/> heart murmur |
| | <input type="checkbox"/> atrial fibrillation | <input type="checkbox"/> palpitations | <input type="checkbox"/> rheumatic fever |
| valve | | | <input type="checkbox"/> irregular heart beat |
| | <input type="checkbox"/> chest pain | <input type="checkbox"/> chest pressure | <input type="checkbox"/> chest tightness |
| | <input type="checkbox"/> leg swelling | <input type="checkbox"/> use nitroglycerin | on exertion |
| | | | <input type="checkbox"/> pain in legs when walking |
| Respiration | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> pneumonia | <input type="checkbox"/> emphysema |
| | <input type="checkbox"/> coughing up blood | <input type="checkbox"/> asthma | <input type="checkbox"/> wheezing |
| | | | <input type="checkbox"/> chronic cough |
| Gastrointestinal | <input type="checkbox"/> appetite | <input type="checkbox"/> hepatitis | <input type="checkbox"/> bloody stools |
| | <input type="checkbox"/> nausea | <input type="checkbox"/> liver trouble | <input type="checkbox"/> diarrhea |
| | <input type="checkbox"/> vomiting | <input type="checkbox"/> jaundice | <input type="checkbox"/> incontinence of |
| | <input type="checkbox"/> gallstones | <input type="checkbox"/> hiatal hernia | stool |
| | | | <input type="checkbox"/> ulcers |
| | | | <input type="checkbox"/> heartburn |
| | | | <input type="checkbox"/> constipation |
| Genitourinary | <input type="checkbox"/> venereal disease | <input type="checkbox"/> bedwetting | <input type="checkbox"/> kidney stones |
| | <input type="checkbox"/> sexually transmitted disease | <input type="checkbox"/> protein in urine | <input type="checkbox"/> sugar in urine |
| | <input type="checkbox"/> bladder infections | <input type="checkbox"/> blood in urine | <input type="checkbox"/> sex drive |
| | | | <input type="checkbox"/> kidney infection |
| | | | <input type="checkbox"/> incontinence |
| Musculoskeletal | <input type="checkbox"/> arthritis | <input type="checkbox"/> back pain | <input type="checkbox"/> disc disease |
| | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> artificial joints | |
| Skin | <input type="checkbox"/> unexplained rashes | <input type="checkbox"/> redness | <input type="checkbox"/> hives |
| | | | <input type="checkbox"/> moles |
| Neurological | <input type="checkbox"/> seizures | <input type="checkbox"/> numbness | <input type="checkbox"/> stroke |
| | <input type="checkbox"/> tingling | <input type="checkbox"/> memory loss | <input type="checkbox"/> mini-stroke |
| | | | <input type="checkbox"/> difficulty walking |
| | | | <input type="checkbox"/> tremor |
| Psychiatric | <input type="checkbox"/> schizophrenia | <input type="checkbox"/> anxiety | <input type="checkbox"/> paranoia |
| | | <input type="checkbox"/> depression | <input type="checkbox"/> bipolar disorder |
| Endocrine | <input type="checkbox"/> diabetes | <input type="checkbox"/> weight gain | <input type="checkbox"/> increased thirst |
| | <input type="checkbox"/> thyroid trouble | <input type="checkbox"/> weight loss | <input type="checkbox"/> breast lumps |
| | | | <input type="checkbox"/> growth delays |
| | | | <input type="checkbox"/> late puberty |
| Hematologic/Lymphatic/Immunologic | <input type="checkbox"/> swollen lymph nodes | <input type="checkbox"/> easy bruising | <input type="checkbox"/> sickle cell |
| | <input type="checkbox"/> lupus | <input type="checkbox"/> anemia | <input type="checkbox"/> nosebleeds |
| | <input type="checkbox"/> abnormal bleeding | <input type="checkbox"/> mumps | <input type="checkbox"/> HIV/AIDS |
| | <input type="checkbox"/> heavy periods | | |