<table>
<tr><th colspan="6">MEDICAL INFORMATION</th></tr>
<tr><td colspan="4">Patient Name:</td><td>DOB:</td><td>Age:</td></tr>
<tr><td colspan="3">Reason for your visit today:</td><td colspan="3">How long have you had this problem?</td></tr>
<tr><th colspan="6">MEDICAL HISTORY</th></tr>
<tr><td>First day of last period:</td><td colspan="2">Do you have regular monthly periods?
☐ Yes ☐No</td><td colspan="2">How often do your periods come?</td><td>Age at first period?</td></tr>
<tr><td>Periods are: ☐Mild ☐Moderate ☐Heavy</td><td colspan="2">How many days does your period last?</td><td colspan="3">Cramps are: ☐Mild ☐Moderate ☐Severe</td></tr>
<tr><td colspan="3">Drug Allergies:</td><td colspan="3">Current Birth Control:
Are you happy with this birth control? ☐ Yes ☐No</td></tr>
<tr><td>Age at first intercourse:</td><td colspan="2">Number of partners(lifetime):</td><td colspan="3">Sexual Preference:
☐ Heterosexual ☐Homosexual ☐Bisexual</td></tr>
<tr><td colspan="3">Have you had a new sexual partner since your last exam?
☐ Yes ☐No</td><td colspan="3">Do you desire testing for STD's? ☐ Yes ☐No</td></tr>
<tr><td>Last Pap Smear:
____/____</td><td colspan="2">Have you ever had an abnormal Pap?☐ Yes ☐No</td><td colspan="3">If yes, please give year and any procedures:</td></tr>
<tr><td>Last Mammogram:
____/____</td><td colspan="2">Have you ever had an abnormal Mammogram? ☐ Yes ☐No</td><td colspan="3">If yes, please give year and any procedures:</td></tr>
<tr><td>How many total pregnancies have you had:</td><td>How many did you deliver?</td><td>How did you deliver?</td><td colspan="3">Number of miscarriages_____
Number of elective terminations_____</td></tr>
<tr><th colspan="5">Hospitalizations/Surgeries(list all <u>except</u> for pregnancy):</th><th>Date of Surgery</th></tr>
<tr><td colspan="5"></td><td></td></tr>
<tr><td colspan="5"></td><td></td></tr>
<tr><td colspan="5"></td><td></td></tr>
<tr><td colspan="2">Do you currently:
☐Exercise regularly
☐Diet-What type?___________
☐Drink alcohol-How much?_______
☐Use recreational drugs?
☐Smoke cigarettes:_____packs/day</td><td colspan="3">Current Medications(please list ALL)/Herbal/Calcium Supplements:</td><td>Do you do monthly breast exams?
☐ Yes ☐No</td></tr>
</table>

MEDICAL HISTORY CONTINUED...

Name: **DOB:**

Are you experiencing any of the following:

- ☐Leak urine when you cough/laugh/sneeze
- ☐Unaware that you are leaking urine
- ☐Strong urge to urinate
- ☐Wear a pad because of urine leakage
- ☐Leaking after intercourse
- ☐Painful urination
- ☐Incomplete urination
- ☐Difficulty beginning to urinate
- ☐Slow urinary stream
- ☐Straining to pass urine
- ☐Irregular Periods
- ☐Pain with your menses
- ☐Pain with ovulation
- ☐Dissatisfied with sexual relations
- ☐Pain with intercourse
- ☐Bleeding between periods
- ☐Bleeding after intercourse
- ☐Bleeding from your rectum

Continued...

- ☐Vaginal discharge
- ☐Vaginal itching
- ☐Vaginal burning
- ☐Breast/Nipple discharge
- ☐Lump(s) in breast
- ☐Breast Pain
- ☐Bloody Urine
- ☐Incomplete urination
- ☐Hot flashes
- ☐Trouble sleeping
- ☐Vaginal dryness
- ☐Night sweats
- ☐Feel anxious
- ☐Feel sad/depressed
- ☐The sight/sound/feel of running water causes you to leak urine
- ☐Feeling of pressure or bearing down
- ☐Bulging from your vagina
- ☐ Unusual hair growth

Please check the box if you have had problems with the following:

- ☐Skin
- ☐Eyes/vision
- ☐Ears/hearing
- ☐Mouth/teeth
- ☐Anemia
- ☐Cancer-What kind?_________
- ☐Diabetes
- ☐Thyroid disease
- ☐Migraines
- ☐Seizures/Epilepsy
- ☐Psychiatric problems
- ☐Depression
- ☐High cholesterol
- ☐Heart disease
- ☐High blood pressure
- ☐Asthma
- ☐Bleeding problems
- ☐Blood transfusions
- ☐Hepatitis
- ☐Lung disease
- ☐Breast lump
- ☐Breast discharge
- ☐Breast surgery
- ☐Gall bladder disease
- ☐Stomach Ulcer
- ☐Black/Bloody stool
- ☐Kidney
- ☐Bladder infections
- ☐Gonorrhea
- ☐Syphilis
- ☐PID
- ☐Hepatitis B
- ☐Trichomonas
- ☐HPV
- ☐Chlamydia
- ☐Genital warts
- ☐Herpes
- ☐HIV/AIDS
- ☐Broken bones
- ☐Back pain
- ☐Joint problems
- ☐Arthritis
- ☐Vaginal infections
- ☐Pelvic tumor
- ☐Pelvic infections
- ☐Abnormal Paps
- ☐Endometriosis
- ☐Fibroids
- ☐Ovarian tumors
- ☐Breast biopsy

Incontinence Questionnaire:

Please answer as accurately as possible.

1. Do you leak urine when you cough, sneeze or laugh? ☐Yes ☐No
2. Do you ever have such an uncomfortably strong need to urinate that if you reach the toilet you will leak? ☐Yes ☐No
3. If "yes" to #2 do you ever leak before you get to the toilet? ☐Yes ☐No
4. How many times during the day do you urinate? _____
5. How many times do you void during the night after going to bed? _____
6. Have you wet the bed in the past year? ☐Yes ☐No
7. Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry? ☐Yes ☐No
8. Do you ever leak during or after sexual intercourse? ☐Yes ☐No
9. Do you find it necessary to wear a pad because of your leaking? ☐Yes ☐No
10. How many times do you leak during the day?_____
11. Have you had bladder, urine, or kidney infections? ☐Yes ☐No
12. Are you troubled by pain or discomfort when you urinate? ☐Yes ☐No
13. Have you had blood in your urine? ☐Yes ☐No
14. Do you find it hard to begin urinating? ☐Yes ☐No
15. Do you have a slow urinary stream? ☐Yes ☐No
16. Do you have to strain to pass your urine? ☐Yes ☐No

FAMILY HISTORY

Are you adopted? ☐ Yes ☐No

Please check all that apply under the appropriate family member:

Disease	Self	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother/ Sister	Other
Alcoholism									
Anemia									
Arthritis									
Asthma/Lung Problems									
Birth Defects									
Bleeding Problems									
Blood Clots									
Bloody Stools/Colon Polyp(s)									
Breast Cancer									
Cervical Cancer									
Colon Cancer									
Depression									
Diabetes									
Heart Disease									
High Cholesterol									
High Blood Pressure									
Kidney Disease/UTI's									
Liver Disease									
Loss of Urine									
Mental Illness									
Osteoporosis									
Ovarian Cancer									
Seizures									
Stomach Ulcers									
Stroke									
Thyroid Disease									
Tuberculosis									
Uterine Cancer									

Other(please explain):