MCKAY UROLOGY – PATIENT HISTORY

Patient Name: _____

Date of Birth: _____

Date of Visit: _____

Pharmacy: _____

Previous Urologist: _____

Primary Care Physician: _____

Group/Practice/Location: _____

Referring Provider: _____

FEMALE PATIENT

MCKAY UROLOGY – PATIENT HISTORY

Patient Name: _____ **Chart #:** _____

REVIEW OF SYSTEMS

- **Please mark ☒ any condition which applies to you.**

General
- ☐ fever
- ☐ chills
- ☐ weakness
- ☐ fatigue

Head and Neck
- ☐ visual disturbances
- ☐ decreased hearing
- ☐ nasal congestion
- ☐ sore throat

Pulmonary
- ☐ shortness of breath
- ☐ cough
- ☐ sputum production
- ☐ wheezing

Cardiovascular
- ☐ chest pain
- ☐ palpitations (irregular heart beat)
- ☐ edema (leg swelling)
- ☐ fainting

Gastrointestinal
- ☐ nausea
- ☐ vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ heartburn
- ☐ abdominal pain

Genitourinary
- ☐ burning on urination
- ☐ bloody urine
- ☐ change in urine stream

Hematopoietic/Lymphatic
- ☐ bruising tendency
- ☐ bleeding tendency
- ☐ swollen lymph glands

Musculoskeletal
- ☐ back pain
- ☐ neck pain
- ☐ joint pain
- ☐ muscle pain

Immunologic
- ☐ immunocompromised
- ☐ recurrent fever
- ☐ recurrent infections

Neurologic
- ☐ abnormal balance
- ☐ confusion
- ☐ numbness
- ☐ tingling
- ☐ headaches

Psychiatric
- ☐ anxiety
- ☐ depression

MCKAY UROLOGY – PATIENT HISTORY

Allergies: Are you allergic to any **medications**? ☐ Yes ☐ No

Specify Medication:	**Describe reaction**
1. _____	☐ anaphylactic shock, ☐ bronchospasm, ☐ rash, ☐ nausea, ☐ other _____
2. _____	☐ anaphylactic shock, ☐ bronchospasm, ☐ rash, ☐ nausea, ☐ other _____
3. _____	☐ anaphylactic shock, ☐ bronchospasm, ☐ rash, ☐ nausea, ☐ other _____
4. _____	☐ anaphylactic shock, ☐ bronchospasm, ☐ rash, ☐ nausea, ☐ other _____

Current Medications – Prescription and over the counter medications
(including vitamins, herbs, aspirin, antacids, injectables, hormones and birth control medication.

Medication:	**Dosage**	**How often do you take this?**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____
15. _____	_____	_____
16. _____	_____	_____
17. _____	_____	_____

MCKAY UROLOGY – PATIENT HISTORY

Medical Condition History

- Please check any of the following conditions you have or have had in the past.
- If none of these conditions apply to you, please proceed to the next page.
- If you are unsure, please ask a staff member to assist you in filling out this form.
- You may have more than one condition.

If you have no medical problems, please check this box: ☐ No medical problems.

☐ Alzheimer's
☐ Anemia
☐ Asthma
☐ Arthritis
☐ Cancer
☐ Cardiac Arrhythmia (abnormal heart rate)
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Other Heart Disease
☐ Cerebrovascular Disease (Stroke)
☐ Depression
☐ Diabetes
☐ Other Endocrine disorder (gland problem, ex: Thyroid)
☐ Emphysema (COPD)
☐ Other Lung Disease
☐ Hypertension (High blood pressure
☐ Hypercholesterolemia (elevated cholesterol)
☐ Kidney Failure
☐ Liver disorder (Cirrhosis, Hepatitis)
☐ Parkinson's Disease
☐ Other Medical Problem (specify):
_____

Surgery/Procedures: Have you had previous surgery? ☐ Yes ☐ No
Please check any surgeries/procedures you have had and give the year the procedure was performed.

Surgery:	**Year**
☐ Appendectomy	_____
☐ Bladder suspension	_____
☐ CABG (Coronary artery bypass grafting)	_____
☐ Cholecystectomy (removal of Gallbladder)	_____
☐ C-Section	_____
☐ Cystocele repair	_____
☐ Hysterectomy – abdominal	_____
☐ Hysterectomy – vaginal	_____
☐ Lithotripsy – ESWL (stone machine)	_____
☐ Mastectomy - left	_____
☐ Mastectomy – right	_____
☐ Rectocele repair	_____
☐ Removal of ovary – left	_____
☐ Removal of ovary – right	_____
☐ Splenectomy (removal of spleen)	_____
☐ Tonsillectomy	_____
☐ Other surgery (1) _____	_____
☐ Other surgery (2) _____	_____
☐ Other surgery (3) _____	_____

MCKAY UROLOGY – PATIENT HISTORY

Family Medical History: **Please check all diseases for which you have a family history:**

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Other: _____

Father: ☐ Alive ☐ Deceased Age _____ (Age deceased or current age if still alive)

Cause of death: _____

Mother: ☐ Alive ☐ Deceased Age _____ (Age deceased or current age if still alive)

Cause of death: _____

Level of Education:

☐ grade school ☐ High school/equivalent ☐ some college ☐ college degree ☐ graduate degree

Habits:

Alcohol: ☐ I drink alcohol
☐ I do not drink alcohol, but I used to drink alcohol
☐ I never drink alcohol

If you do drink alcohol, how many drinks do you average per week? _____ per week

Number of years of this pattern? _____ years.

Tobacco: ☐ I use tobacco
☐ I do not use tobacco, but I used to use tobacco
☐ I have never used tobacco

If you use tobacco, how much?

# of cigarette packs per day:? _____ # of Cigars per week? _____

# of pipe bowls per day? _____ # of snuff, dip, or chew packages per week? _____

# of years of use at this pattern? _____ years.

Date of last tobacco use: _____

Current daily caffeine use:

Cups of coffee per day: _____ 1 cup = 8 oz.

Glasses of tea per day: _____ 1 glass = 12 oz.

Glasses of soda per day: _____ 1 glass = 12 oz.

MCKAY UROLOGY – PATIENT HISTORY

Please describe, in your own words, the bladder problems you are having.

_____

When did your bladder problems begin? _____ (Month/Year)

Are your current symptoms: _____ Worsening _____ Static/same _____ Improving

On a scale of 0 to 10 (0 = not at all; 10 = intolerable), how much do your bladder problems bother you? _____

Voiding Habits:

How often do you urinate during your waking hours?

_____ Every hour or more often
_____ Every 1-2 hours
_____ Every 2-3 hours
_____ Every 4 hours or more

Do you wake up at night to urinate?

_____ Never or rarely
_____ 1 time
_____ 2-3 times
_____ 4 or more times

Do you have an uncomfortable or strong urge to pass urine and need to hurry to the toilet (urgency)?

_____ Never or rarely
_____ Rarely
_____ Occasionally
_____ Daily

Irritative voiding symptoms: Please check all that apply to you

_____ Inability to make it to the bathroom in time.
_____ Need to void when you hear running water.
_____ Need to void when rising from a seated position.

Obstructive voiding symptoms: Please check all that apply to you

_____ Poor urinary stream strength or slow to start urinary stream (hesitancy)
_____ Need to push or strain to begin urination (Créde)
_____ A feeling of not being able to empty your bladder completely
_____ Need to push on your abdomen to empty your bladder
_____ Urinary stream starts and stops before your bladder is empty
_____ Need to reposition your body in order to void more fully (pelvic tilt)
_____ Need to catheterize in order to empty your bladder fully

MCKAY UROLOGY – PATIENT HISTORY

Incontinence:

Do you have urinary leakage (incontinence)? ____ Yes ____ No. If yes, check when this typically occurs.

_____ During the daytime.
_____ During the nighttime.
_____ Continuously.
_____ Without awareness.

Please check the activities that cause you to leak urine.

____ coughing ____ sneezing ____ laughing ____ sexual intercourse
____ lifting ____ sports activities ____ change of position ____ rising from a chair
____ other activities

How much urine do you leak? (please check the most appropriate answer)

_____ A small amount (just a few drops)
_____ A moderate amount (more than a few drops/dribbling)
_____ A large amount (flooding/total saturation)

Do you wear protection (pads, diapers, etc.)? ____ Yes ____ No

Type/brand: _____

How many times do you change pads during the day? _____

When you change pads are they (please check the most appropriate answer)

____ Dry ____ Moist ____ Damp ____ Wet ____ Soaked

Prolapse Symptoms: Please check all that apply to you

_____ Vaginal pressure or vaginal heaviness
_____ Observation of tissue protruding from the vaginal area
_____ Need to push the protrusion back in order to empty your bladder or have a bowel movement
_____ Low back pain
_____ Vaginal pain
_____ Abdominal pressure

General Symptoms: Please check all that apply to you

_____ Visualized blood in urine or pink urine (hematuria)
_____ Pain with urination (dysuria)
_____ History of urinary tract infections. If checked, when was last infection?_____
_____ History of kidney infections (pyelonephritis)
_____ History of kidney stones. If checked, when was last stone episode? _____

MCKAY UROLOGY – PATIENT HISTORY

Bowel Symptoms: Please check all that apply to you

_____ Problems with constipation
_____ Laxative use. If checked, how often; # of times per week used: _____
_____ Digital manipulation of bowel movements
_____ Painful bowel movements
_____ Fecal urgency
_____ Incontinence of flatus (gas)
_____ Incontinence of liquid stool
_____ Incontinence of solid stool
_____ Feeling of incomplete emptying

Pregnancy History:

_____ # of pregnancies
_____ # of vaginal births
_____ # of C-Section births

Sexual Function: Please check those that apply to you

_____ Peri-menopausal (experiencing symptoms of menopause, such as hot flashes, irregular menstrual periods)
_____ Menopausal (no longer having periods)
_____ Sexually active
_____ Not sexually active. Comments:_____
_____ Pain with intercourse
_____ Lack of desire for intercourse
_____ Lack of lubrication (vaginal wetness) with intercourse
_____ Inadequate arousal for intercourse
_____ Satisfied with sex life.

Have you had previous studies on your bladder? ____ Yes ____ No

If yes, when did you have these studies? _____ (month/year).

Where was testing performed? _____