NEW PATIENT INTAKE (FEMALE)

First Name	MI	Last Name	Medical Record #

PREFERRED PHARMACY (Name/Address/Phone): _____

MY MAIN PROBLEMS:
☐ Blood in urine ☐ Bladder Cancer ☐ Bladder Infection
☐ Bladder Pain ☐ Kidney Stones ☐ Interstitial Cysitis ☐ Leak Urine
☐ Overactive Bladder ☐ Dropped Bladder ☐ Other: _____

ALLERGIES: ☐ None ☐ PCN ☐ Sulfa ☐ Cipro ☐ Iodine/Contrast

☐ Other: _____

MEDICATIONS: _____

_____

_____

SURGICAL HISTORY: ☐ **No Changes** ☐ Childbirth: C-Section # _____ Vaginal Delivery # _____
☐ Kidney Stone Surgery ☐ Appendectomy ☐ Back/Hip/Knee ☐ Bladder Tack ☐ Cystoscopy
☐ Gallbladder ☐ Heart Bypass ☐ Hysterectomy ☐ Sling (TVT) ☐ Lithotripsy
☐ Other:_____

MEDICAL HISTORY: ☐ **No Changes** ☐ Diabetes ☐ Emphysema ☐ Heart Attack
☐ Heart Murmur ☐ Hepatitis ☐ Hernia ☐ Hypertension ☐ Parkinson's
☐ Strokes ☐ Cancer: _____ ☐ Pregnant ☐ Menopause
☐ Other: _____ Last Period:_____

FAMILY HISTORY: ☐ Kidney Cancer ☐ Kidney Stones ☐ Heart Disease

SOCIAL HISTORY: Occupation: _____ ☐ Retired
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Smoke: ☐ No ☐ Yes

MY SYMPTOM(S):

General/Constitutional	☐ Fever	☐ Weight Loss	☐ Chills
Eyes	☐ Blurry Vision	☐ Double Vision	☐ Cataracts
Ears, Nose, Mouth, Throat	☐ Hearing Loss	☐ Nasal Stuffiness	☐ Sore Throat
Cardiovascular	☐ Chest Pains	☐ Swollen Ankles	☐ Irregular Heartbeat
Respiratory	☐ Wheezing	☐ Chronic Cough	☐ Shortness of Breath
Gastrointestinal	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Change in Bowels
Genitourinary	☐ Incontinence	☐ Painful Urination	☐ Blood in Urine
Musculoskeletal	☐ Chronic Back Pain	☐ Chronic Neck Pain	☐ Sore Muscles
Integumentary/Skin	☐ Rash	☐ Persistent Itching	☐ Skin Cancer History
Neurologic	☐ Numbness	☐ Tingling	☐ Dizziness
Hematologic/Lymphatic	☐Swollen Glands	☐ Abnormal Bleeding	☐ Transfusion History

URINARY SYMPTOM(S):
☐ Frequency ☐ Urgency ☐ Leakage ☐ Straining ☐ Abdominal pain
☐ Bladder pain ☐ Pain in side: R / L ☐ Not emptying bladder ☐ Urinating at night (# _____)

In compliance with California OHSA Title 8, Section 5199, healthcare facilities must prescreen patients for aerosol transmissible diseases. Please let the nurse know if you have any of the following:

Yes No History or Symptoms of Tuberculosis *(productive cough, bloody sputum, fever, malaise, night sweats, unexplained weight loss)*

Yes No Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis