DATE:___/___/20___

FEMALE PATIENT GU HISTORY FORM

PATIENT NAME:____ DOB: ________________________

DO YOU HAVE, OR HAVE YOU RECENTLY HAD, ANY OF THE FOLLOWING SYMPTOMS?
(PLEASE CIRCLE YOUR RESPONSE):

ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT? YES NO

BEDWETTING? YES NO

BLOOD IN THE URINE? YES NO

DAYTIME WETTING OF CLOTHES? YES NO

DISCHARGE OR PUS FROM THE VAGINA? YES NO

FREQUENCY (URINATION MORE THAN NORMAL)? YES NO

HOW OFTEN DURING THE DAY? ___________________

HOW MANY TIMES AT NIGHT? ____________________

HISTORY OF SEXUALLY TRANSMITTED DISEASE
(STD, VD, Herpes, Gonorrhea, Chlamydia, etc.)? YES NO

KIDNEY INFECTON (PYELONEPHRITIS)? YES NO

LOSS OF URINE (LEAKAGE, INCONTINENCE) WITH COUGHING OR SNEEZING? YES NO

LOSS OF URINE IF YOU DON'T GET TO THE BATHROOM IMMEDIATELY? YES NO

PAIN OR BURNING WITH URINATION?

PAIN WITH/AFTER SEXUAL INTERCOURSE? YES NO

SKIN PROBLEMS/RASH IN THE GROIN/GENITAL AREA? YES NO

STONES IN THE KIDNEY OR BLADDER (NOT gallbladder) YES NO

URINARY TRACT INFECTION (UTI, BLADDER INFECTION)? YES NO

WEAK, DRIBBLING STREAM OR TOUBLE STARTING HIS/HER URINE? YES NO