PRINCE WILLIAM UROLOGY ASSOCIATES, LTD

Ali M Sajadi, MD - Andrew K Chung, MD - Amy K Moreno, MD - Anshu Guleria, MD – Katie Riley, PA-C

New Patient Urologic History Form - Women

Patient's Name: _____
(Last) (First) (MI) (Date)

Age: _____ DOB: _____ Height _____ Weight _____

Referring Dr: _____ Primary Dr:_____

What is the ***main reason*** for your visit today? Write in your own words on the lines provided:

_____

_____

When did you first notice the problem? _____

Location of the problem? (You may choose more than one location)

☐ Abdomen ☐ Pelvis ☐ Flank
☐ Back ☐ Penis ☐ Bladder
☐ Groin ☐ Rectum ☐ Genitalia
☐ Not applicable

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem.

1 2 3 4 5 6 7 8 9 10 N/A

How long does the problem last? _____Is the problem: ☐ Constant ☐ Variable ☐ Seldom

Does anything make the problem worse?_____If yes, what makes it worse? _____
Does anything make the problem better? _____ If yes, what makes it better? _____

Does the problem interfere with your normal activities? ☐ Yes ☐ No

What testing have you had to evaluate your urological problem?

☐ I have had no tests to evaluate this problem
☐ X-ray ☐ Ultrasound ☐ Urodynamic Testing
☐ CT scan ☐ Nuclear bone scan ☐ Other: _____
☐ MRI ☐ Nuclear renal scan ☐ Unsure
☐ IVP ☐ Urine specimen
☐ Blood tests ☐ Cystoscopy
Where was the test performed? _____

8525 Rolling Rd, Suite 220 Manassas, VA 20110-3648
Phone: (703) 393-0700; Fax: 703-393-0661

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Do you experience any of the following?

☐ Urinary urgency ☐ Weak stream ☐ Dribbling
☐ Urinary frequency ☐ Straining to urinate
☐ Burning with urination ☐ Trouble starting stream

How many times do you wake up to urinate at night? 0 1 2 3 4 5 6 7 8 9 10

Do you feel like your emptying your bladder completely? ☐ Yes ☐ No

Do you leak urine? ☐ Yes ☐ No

Is your leakage associated with the urge to urinate? ☐ Yes ☐ No

Is your leakage associated with coughing, laughing, jumping, sneezing, or exercising? ☐ Yes ☐ No

Do you wear protective pads? ☐ Yes ☐ No

How many Pads/day? _____ Liners/day? _____ Diapers/day? _____ Other: _____

Are they usually: ☐ Dry ☐ Moist ☐ Wet ☐ Soaked

Are there any other urologic issues you would like to discuss with Dr. _____today? ☐ Yes ☐ No

(Please explain:) _____

Allergies: Are you allergic to:

☐ Latex ☐ Iodine/Betadine ☐ Penicillin
☐ Dye/IV Contrast ☐ Tape/Adhesives ☐ Sulfa
☐ Shellfish/Shrimp! ☐ Anesthetics ☐ Cipro/Levaquin

☐ I have no medication allergies

Medication allergies: (List all)

_____

Medications:
Do you take any medications? ☐ Yes ☐ No

Are you currently taking the following blood thinners? ☐ Aspirin ☐ 81 mg or ☐ 325 mg
☐ Motrin ☐ Aleve ☐ Ibuprofen ☐ Celebrex ☐ Mobic ☐ Other: _____
☐ Coumadin ☐ Warfarin ☐ Plavix ☐ Pradaxa ☐ Xarelto ☐ Eliquis ☐ Heparin ☐ Lovenox

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Please list all the medications you take with the dosage and frequency:

Medication	***Dose***	***How Often***

Please list all Vitamins & Supplements such as Vitamin E, Fish oil, Herbal preparation, Garlic, etc:

Past & Present Medical Problems

- ☐ Irregular heartbeat
- ☐ Carotid artery disease
- ☐ Congestive heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Peripheral vascular
- ☐ Heart valvular disease
- ☐ Renal artery stenosis
- ☐ Heart disease
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Cystic fibrosis
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Sarcoidosis
- ☐ Sleep apnea
- ☐ Tuberculosis
- ☐ Cirrhosis
- ☐ Crohn's disease
- ☐ Heartburn/GERD
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Diverticulosis
- ☐ Kidney failure
- ☐ Endometriosis
- ☐ Polycystic kidney disease
- ☐ Kidney stones
- ☐ Vesicoureteral reflux
- ☐ Kidney infections/UTI
- ☐ Kidney obstruction
- ☐ Enlarged prostate/BPH
- ☐ Prostate infection
- ☐ STD's
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Polio
- ☐ Artificial joints
- ☐ Lupus
- ☐ Addison's Disease
- ☐ Cushing's disease
- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Alzheimer's
- ☐ Multiple sclerosis
- ☐ Myasthenia gravis
- ☐ Parkinson disease
- ☐ Seizures
- ☐ TIA
- ☐ Anemia
- ☐ Sickle cell anemia
- ☐ Blood clots
- ☐ HIV/AIDS
- ☐ Glaucoma
- ☐ Drug dependency
- ☐ Depression
- ☐ Bladder cancer
- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Colon cancer
- ☐ Kidney cancer
- ☐ Lung cancer
- ☐ Penile cancer
- ☐ Prostate cancer
- ☐ Skin cancer
- ☐ Testicular cancer
- ☐ Uterine cancer
- ☐ Cancer, Other:

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☐ Irritable bowel	☐ Bipolar	☐ Other:_____
☐ Peptic ulcer disease	☐ Stroke	_____
☐ Ulcerative colitis	☐ Dementia	_____

Female history

Number of pregnancies:__ _____ Number of Deliveries: _____ ☐ Vaginal ☐ C-Section
Have you had a hysterectomy? ☐ Yes ☐ No When? ___ Why? _____
Have you had any prior bladder surgeries/when?_____
Have you had a bladder tack/when?_____
Have you had a sling/when? _____

Surgical History

Date	Surgery	Date	Surgery

Family History (please indicate which family member)

☐ Urinary infections	☐ Kidney stones	☐ Prostate cancer
☐ Bleeding disorders	☐ Diabetes	☐ Kidney cancer
☐ Heart disease	☐ Bladder cancer	☐ Other:_____

Tobacco/ Alcohol History

Do you currently smoke? ☐ Yes ☐ No How much? _____
Did you smoke in the past? ☐ Yes ☐ No How long? _____ When did you quit? _____
Do you drink alcohol? ☐ Yes ☐ No How many drinks per day? _____
Do you use recreational drugs? ☐ Yes ☐ No Substances: _____

Thank you for taking the time to complete your urological health questionnaire. Welcome to our practice! Prince William Urology Associates, Ltd.

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REVIEW OF SYSTEMS

Name: _____ **Date:** _____

Please ☑ check only the problems that **currently** apply to you

CONSTITUTIONAL

☐ Fever
☐ Chills
☐ Weight gain
☐ Weight loss

EYES

☐ Blurred vision
☐ Vision loss

EARS/ NOSE/ THROAT

☐ Hearing loss
☐ Sinus problems
☐ Difficulty swallowing
☐ Sore throat
☐ Dental problems
☐ Nose bleeds

CARDIOVASCULAR

☐ Chest pain
☐ Palpitations
☐ Irregular heartbeat
☐ Swelling of feet/ Extremities

RESPIRATORY

☐ Shortness of breath
☐ Chronic cough
☐ Coughing up blood

GASTROINTESTINAL

☐ Poor appetite
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Abdominal pain
☐ Blood in stool
☐ Heartburn

GENITOURINARY

☐ Blood in urine
☐ Easy bruising
☐ Leakage of urine
☐ Weak stream
☐ Frequency urination
☐ Urge to void suddenly
☐ Getting up at night to Urinate
☐ Problems with erection
☐ Pain with intercourse
☐ Bladder pain
☐ Pelvic pain
☐ Burning with urination
☐ Frequent urine infections

MUSCULOSKELETAL

☐ Back pain
☐ Joint pain
☐ Muscle aches

INTEGUMENTARY/SKIN

☐ Rash
☐ Atypical moles
☐ Itchy skin

NEUROLOGIC

☐ Numbness
☐ Weakness
☐ Dizziness

HEMATOLOGIC/ LYMPHATIC

☐ Bleeding tendency
☐ Swollen lymph gland

ENDOCRINE

☐ Excessive thirst
☐ Hot/cold Intolerance
☐ Hormone problem
☐ Fatigue

ALLERGY

☐ Medication allergy
☐ Latex allergy
☐ Seasonal allergy

PSYCHIATRIC

☐ Depression
☐ Anxiety

****Healthcare provider only:** The above systems have been reviewed by: _____
Physician's initials

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