

FEMALE
UROLOGICAL WORK-UP

Today's Date _____

Name _____ Age _____ Family Doctor or Referring Physician _____

CURRENT MEDICATIONS _____

WHAT IS THE REASON WHY YOU ARE HERE? _____

When was your last pelvic examination? _____ Pap Smear? _____

Number of Pregnancies _____ Miscarriages _____

When was your last menstrual period? _____ Periods regular? Yes ___ No ___

Have you ever had any pelvic surgery? _____ Yes ___ No ___

If yes, when? _____ What for? _____

Do you have a family history of cancer of the bladder, kidney, uterus, breast or a history of high

Blood pressure? _____ Yes ___ No ___

Do you smoke? _____ Yes ___ No ___

Have you ever been told that you had _____ Kidney Infections Yes ___ No ___

Kidney Stones Yes ___ No ___

Bladder Infections Yes ___ No ___

High Blood Pressure Yes ___ No ___

Cancer: Uterus, Yes ___ No ___

Cervix, Breast. Yes ___ No ___

DO YOU HAVE TO:

Strain to get the water started (urinate)? _____ Yes ___ No ___

Urinate more frequently than normal? _____ Yes ___ No ___

Get up at night to urinate? _____ Yes ___ No ___

If yes, circle the number of times 1 2 3 4 5 6 7 or more

Go immediately when you get the urge? _____ Yes ___ No ___

During the day how often do you urinate 1 2 3 4 5 6 7 or more

HAVE YOU HAD TO, OR DO YOU HAVE TO:

Take longer to empty the bladder than usual? _____ Yes ___ No ___

A decrease in the size of your stream? _____ Yes ___ No ___

A feeling of not emptying your bladder? _____ Yes ___ No ___

Burning or pain with urination? _____ Yes ___ No ___

If yes, during or after? _____

Pain? Back _____ Abdomen _____ Pelvis _____ Above pubis _____

Blood in the urine? _____ Yes ___ No ___

If yes, was it throughout the stream? _____ At the beginning only? _____

At the end only? _____

Loss of urine when you strain? _____ Yes ___ No ___

Such as lifting, coughing, sneezing, etc.

Loss of urine if you don't get to the bathroom on time? _____ Yes ___ No ___

Loss of urine at other times? _____ Yes ___ No ___

A vaginal infection or discharge? _____ Yes ___ No ___

Any other Urological problems? _____ Yes ___ No ___

Have you ever seen a Urologist or Kidney Specialist before? _____ Yes ___ No ___

Have you ever had an IVP? (Kidney x-ray) _____ Yes ___ No ___

Have you ever had urinary surgery? _____ Yes ___ No ___

If so, When? _____ For What? _____