

Orange County Urology Associates –Patient Information Form (Female)

Office Use Only

Name: _____ Today's Date: _____

Date	ROS by

Present Illness

How has your urologic condition changed since your last visit? Better Same Worse

Current Urinary Symptoms

- | | |
|--|---|
| <input type="checkbox"/> Frequency of urination | <input type="checkbox"/> Incontinence (Involuntary Loss of Urine) |
| • Number of voids during the day? _____ | <input type="checkbox"/> with urgency |
| • Number of voids during the night? _____ | <input type="checkbox"/> with cough or sneeze |
| <input type="checkbox"/> Urgency | <input type="checkbox"/> Number of pads used per day? _____ |
| <input type="checkbox"/> Burning/ Painful urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Urethral discharge | <input type="checkbox"/> Flank Pain |
| <input type="checkbox"/> Date of last menstrual period: ____/____/____ | <input type="checkbox"/> Fevers/Chills |

Medications

Have there been any changes to your medications? No Yes, please note changes below

<i>Name of Medication</i>	<i>Dose</i>	<i>Times per Day</i>	<i>Name of Medication</i>	<i>Dose</i>	<i>Times per Day</i>

Have you had any new side effects to medicine? No Yes, list drug/effects

Allergies

NO KNOWN DRUG ALLERGIES

List medications to which you are allergic.

Drug Name: _____

Drug Name: _____

Please describe the reaction.

Allergic Reaction: _____

Allergic Reaction: _____

Have you had any hospitalizations since your last visit? No Yes, please section complete below

When: _____ Reason: _____

Have you had any surgeries since you last visit? No Yes, please section complete below

Date: _____ Surgery: _____

Do you have any new medical problems since your last visit? No Yes, please list conditions below
