Orange County Urology Associates –Patient Information Form (Female)

Name: _____ **Today's Date:** _____

Office Use Only	
Date	ROS by

Present Illness

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

_____

_____

_____

_____

Current Urinary Symptoms

☐ Frequency of urination
- Number of voids during the day? _____
- Number of voids during the night? _____

☐ Urgency
☐ Burning/ Painful urination
☐ Urethral discharge
☐ Date of last menstrual period: _____

☐ Incontinence (Involuntary Loss of Urine)
- ☐ with urgency
- ☐ with cough or sneeze
- ☐ Number of pads used per day? _____

☐ Blood in urine
☐ Flank Pain
☐ Fevers/Chills

Medications

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

Name of Medication	*Dose*	*Times per Day*	*Name of Medication*	*Dose*	*Times per Day*

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. Please describe the reaction.

Drug Name: _____ **Allergic Reaction:** _____

Drug Name: _____ **Allergic Reaction:** _____

Do you have **sleep apnea**? ☐Yes ☐No Pacemaker? ☐Yes ☐No

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

_____ _____

_____ _____

_____ _____