



at Virginia Women's Center

John Rolfe Commons
 2240 John Rolfe Parkway
 Richmond, VA 23233
 (804) 288-4084
 FAX: 545-9548

Personal / Family History

PATIENT HISTORY

Please indicate if you have had the illness/disease.

- | | |
|---|---|
| <input type="radio"/> Colon Cancer | <input type="radio"/> Respiratory Disease |
| <input type="radio"/> Breast Cancer | <input type="radio"/> Headaches (Migraine) |
| <input type="radio"/> Lung Cancer | <input type="radio"/> Blood Clots |
| <input type="radio"/> Ovarian Cancer | <input type="radio"/> Psychiatric Care |
| <input type="radio"/> Uterine Cancer | <input type="radio"/> PMS |
| <input type="radio"/> Bladder Cancer | <input type="radio"/> Endometriosis |
| <input type="radio"/> Kidney Cancer | <input type="radio"/> Frequent Bladder Infections |
| <input type="radio"/> Other Cancers | <input type="radio"/> Incontinence |
| <input type="radio"/> Depression | <input type="radio"/> Blood in urine |
| <input type="radio"/> Diabetes | <input type="radio"/> Uterine Fibroids |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Recurrent Ovarian Cysts |
| <input type="radio"/> Heart Disease | <input type="radio"/> Anesthetic Complications |
| <input type="radio"/> Kidney Stones | <input type="radio"/> Autoimmune Disorder |
| <input type="radio"/> Kidney Disease | <input type="radio"/> Blood Transfusions |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Hepatitis/Liver Disease |
| <input type="radio"/> Stroke | <input type="radio"/> Infertility |
| <input type="radio"/> Thyroid Disease | <input type="radio"/> Other Medical Problems |
| <input type="radio"/> Weight Disorders | <input type="radio"/> None Apply |
| <input type="radio"/> Seizures | |

FAMILY HISTORY

Please indicate if any member of your family have had these illnesses/diseases.

- | | |
|---|--|
| <input type="radio"/> Family History Unknown | <input type="radio"/> UTI |
| <input type="radio"/> Colon Cancer | <input type="radio"/> Blood in urine |
| <input type="radio"/> Breast Cancer | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Lung Cancer | <input type="radio"/> Stroke |
| <input type="radio"/> Ovarian Cancer | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Uterine Cancer | <input type="radio"/> Weight Disorders |
| <input type="radio"/> Bladder Cancer | <input type="radio"/> Seizures |
| <input type="radio"/> Kidney Cancer | <input type="radio"/> Respiratory Disease |
| <input type="radio"/> Other Cancers | <input type="radio"/> Headaches (Migraine) |
| <input type="radio"/> Depression | <input type="radio"/> Blood Clots |
| <input type="radio"/> Diabetes | <input type="radio"/> Psychiatric Care |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Endometriosis |
| <input type="radio"/> Heart Disease | <input type="radio"/> Other Medical Problems |
| <input type="radio"/> Kidney Disease | <input type="radio"/> None Apply |
| <input type="radio"/> Kidney stones | |

SURGICAL HISTORY

Please indicate if you have had any of the following:

- | | |
|---|--|
| <input type="radio"/> Hysterectomy, Abdominal | <input type="radio"/> Cesarean Section |
| <input type="radio"/> Hysterectomy, Vaginal | <input type="radio"/> Surgery for Abnormal Pap |
| <input type="radio"/> Ovaries Removed | <input type="radio"/> Gall Bladder Removed |
| <input type="radio"/> Laparoscopies | <input type="radio"/> Appendectomy |
| <input type="radio"/> Breast Biopsy or Lumpectomy | <input type="radio"/> Tonsillectomy |
| <input type="radio"/> Mastectomy | <input type="radio"/> Bladder tack / sling |
| <input type="radio"/> Tubal Ligation | <input type="radio"/> Other Surgeries |
| <input type="radio"/> Collagen | |

SOCIAL HISTORY

- Married Divorced Single Widowed

Occupation: _____

- Yes No Have you ever seen a urologist?

If Yes, who? _____

- Yes No Any Recent kidney X-Rays?