HOLLY KAY WYNESKI, MD
FEMALE UROLOGY

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ DOB:_____/_____/_____Today's Date:____/____/_____

Personal Medical History

Have you ever been diagnosed with?

Stroke	Yes	No
Thyroid Disease	Yes	No
Asthma	Yes	No
Anemia/Blood Transfusion	Yes	No
Blood Clots: Circle -> Leg or Lung	Yes	No
Heart Attack/Murmur/Mitral Valve Prolapse	Yes	No
High Blood Pressure	Yes	No
Diabetes or Gestational Diabetes	Yes	No
Seizures/Convulsion/Epilepsy/Migraines	Yes	No
Fracture (location):	Yes	No
Bowel Issues/Crohn's/Diverticulitis	Yes	No
Hepatitis/Yellow Jaundice	Yes	No
Thrombophilia Specify:	Yes	No
Kidney Stones/Infections	Yes	No
Sexually Transmitted Disease (type)	Yes	No
Female Cancer	Yes	No

Name: _____ Date of Birth: _____ Today's date: _____

Medications (Including Vitamins and Herbal Supplements)

Medication	**Dosage**

Allergies _____

Local Pharmacy _____

Mail Order Pharmacy _____

Current Social History

Smoke	Yes	No	How Long		Year Quit
Alcohol	Yes	No	How Many		
Exercise	Yes	No	How Long		
Domestic Violence	Yes	No			

Previous Surgeries

Type	**Date**

Family History

Breast Cancer	Yes	No	Who	
Colon Cancer	Yes	No	Who	
Ovarian Cancer	Yes	No	Who	
Uterine Cancer	Yes	No	Who	
Other Cancer	Yes	No	Who	
Blood Clots (DVT or PE)	Yes	No	Who	
Miscarriages	Yes	No	Who	
Diabetes	Yes	No	Who	
Heart Disease	Yes	No	Who	
Osteoporosis	Yes	No	Who	
Endometriosis	Yes	No	Who	
Infertility	Yes	No	Who	
Von Willebrand	Yes	No	Who	
Bleeding/Discharge	Yes	No	Who	
Cystic Fibrosis	Yes	No	Who	

Overactive Bladder:

Do you have overactive bladder? _____ Yes _____ No

What medication do you currently take: _____

What medications have you tried and failed in the past? Please check.

_____ Oxybutynin or Ditropan _____ Detrol LA or Tolterodine _____ Sanctora or Trospium

_____ Vesicare or Solifenacin Succinate _____ Myrbetriq or Mirabegron _____ Toviaz or Fesoterodine

Other: _____s

Any other Medical Problems:

_____

_____

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