

Medical History Form

Provided by the National Association For Continence (NAFC)

To help you prepare for your first appointment with your healthcare provider, we have provided this *sample medical history form. To protect your privacy, NAFC is not capturing any personal information relating to medical history so it is not possible to complete this form online. You may print a copy and fill in your answers by hand. If you have questions regarding any of the terms on this form, please refer to NAFC's online glossary for assistance.

Name _____

Date _____

Gender Male Female

Age _____

1. Education:

- Less than high school
 Completed high school
 More than high school

2. Occupation (now or last job):

3. Date of last complete medical exam:

- Within last month
 Within last 6 months
 More than 6 months

4. Allergies (medications, foods, or other):

Substance Allergic To Reaction

| | |
|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |

5. Do you drink alcohol?

- Yes No

If yes, indicate number of glasses per week:

Beer (glasses)

Wine (glasses)

Spirits (ounces)

6. Indicate what amount you drink of the following in a typical day

Water (8 oz. glasses)

Juice (8 oz. glasses)

Coffee (cups)

Tea (cups)

Soda (8 oz. glasses)

7. Have you ever been diagnosed or treated for cancer, a tumor, or noticed any lumps or swelling?

Yes No

If yes, please describe:

8. Have you ever been treated for any of the following:

| | Yes | No |
|------------------|--------------------------|--------------------------|
| Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervous problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> |
| Drug addiction | <input type="checkbox"/> | <input type="checkbox"/> |

9. Do you have trouble with:

| | Yes | No |
|--|--------------------------|--------------------------|
| Feeling of tingling or numbness in any parts of your body | <input type="checkbox"/> | <input type="checkbox"/> |
| Weakness in your arms and legs | <input type="checkbox"/> | <input type="checkbox"/> |
| Weakness in one side of your body | <input type="checkbox"/> | <input type="checkbox"/> |

10. Please select the appropriate option if you use any of the following:

Cane Wheelchair Walker

11. Do you smoke?

Yes No

If yes, how many of the following every day?:

Cigarettes

Cigars

Pipe

Chew tobacco

Recreational drugs

12. List all medications you are currently taking (prescription and over-the-counter):

| Name | Dosage | Reason for Taking |
|------|--------|-------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

13. Which, if any, of the following have you been treated for?

- | | | |
|---|---|---|
| <input type="checkbox"/> Alzheimer's disease/dementia | <input type="checkbox"/> Falls | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fractures/joint replacements | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head injuries | <input type="checkbox"/> Polyps |
| <input type="checkbox"/> Back injuries/back compression fractures | <input type="checkbox"/> Heart disease (CAD, arrhythmia, atrial fibrillation) | <input type="checkbox"/> Renal disease |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Skin sensitivities or conditions |

- | | | |
|---|---|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Vascular disease/PVD |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Irritable bowel | |
| <input type="checkbox"/> Constipation/impaction | <input type="checkbox"/> Kidney stones/bladder stones | |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Mitral valve prolapse | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | |

Other, specify:

Urological Review - Both Men and Women

14. Prior Genitourinary history:

- | | |
|--|--|
| <input type="checkbox"/> Hysterectomy <input type="text"/> yr. | <input type="checkbox"/> Bladder tumor |
| <input type="checkbox"/> Vaginal | <input type="checkbox"/> Bladder surgery |
| <input type="checkbox"/> Abdominal | <input type="checkbox"/> Pelvic radiation |
| <input type="checkbox"/> Ovaries removed | <input type="checkbox"/> Prostatitis/BPH |
| <input type="checkbox"/> Urethral stricture/dilatation | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Discharge - genital area | <input type="checkbox"/> Collagen infections |
| <input type="checkbox"/> Urinary tract infection | |

Date:

Type:

Other, specify:

Gynecological Review - Women Only

15. Gynecological review

Prolapse

Bladder Uterus

Rectum

Menstrual cycle information

Date of last period

Date of last pap smear

Pregnancy and childbirth information

Use of:

Pessary IUD Diaphragm

Birth Control

Specify

of Pregnancies

of Vaginal deliveries

of Cesarean sections

of Episiotomies

Previous surgery:

*This form was adapted from Managing and Treating Urinary Incontinence by Diane Kaschak Newman RN, MSN, FAAN.