UROLOGY SPECIALISTS, P.C.
KCUC A DIVISION OF KANSAS CITY UROLOGY CARE, PA

Patient Name: **Date of Birth:** **Today's Date:**

FEMALE HEALTH INVENTORY

Age at onset of menstruation:		
Have you undergone menopause?	☐ Yes	☐ No
If no, date of last menstruation:		
If no, do you have heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of your period?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Have you SEEN blood in your urine?	☐ Yes	☐ No
Any frequency of urination?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
If yes, do you leak urine with coughing, sneezing, or vigorous activity?	☐ Yes	☐ No
If yes, do you leak urine due to a sudden feeling of urgency?	☐ Yes	☐ No
If yes, how many pads do you use a day? None 1-2 2-3 3-4 4-5 5 or more		
Any hot flashes or sweating at night?	☐ Yes	☐ No
Date of your last pap smear?		
Date of your last rectal exam?		