

Please answer all questions to the best of your ability. **Date** _____

Patient Name _____ Date of Birth _____ Sex M ___ F ___

- Full name of the doctor who sent you for evaluation _____
Address _____ Phone _____
- Full name of family doctor if not same as above _____
Address _____ Phone _____

I. HISTORY OF PRESENT ILLNESS: New Patient

1. Main reason you are seeing the doctor today _____
2. For what length of time have you had this problem? _____

II. UROLOGIC HISTORY:

1. Have you ever seen a urologist before YES ___ NO ___ Name _____
2. Why did you see a urologist _____

Circle YES or NO: Men/Women

Painful Urination	YES NO	Urinate too often	YES NO	Slow Urination	YES NO	Urinary Incontinence	YES NO
Urinary Infection	YES NO	Bladder stone	YES NO	Kidney Disease	YES NO	Renal Transplant/Donor	YES NO
Dialysis	YES NO	Blood in the urine	YES NO	Urinary problem as child	YES NO	Impotence	YES NO
Kidney Stones	YES NO	Had to wear catheter	YES NO	Injury to urinary system	YES NO		

MEN: Prostate BPH/Prostatitis YES NO Abnormal PSA YES NO Prostate Bx/Prostate Cancer YES NO

III. PAST MEDICAL HISTORY

1. Are you allergic to any medication YES ___ NO ___
Please list allergies (such as penicillin, sulfa, aspirin latex, mycins, codeine, morphine or IVP dye)
a. _____, b. _____, c. _____, d. _____.
2. Are you currently taking any prescription medicines? YES ___ NO ___, if yes please list drug name, dosage and how taken:
a. _____ b. _____
c. _____ d. _____
e. _____ f. _____
3. Have you ever had a reaction to anesthesia? YES ___ NO ___.
4. List all surgeries you have had and date:
a. _____ b. _____
c. _____ d. _____

5. Have you ever had any of the following? Circle all of those below that apply.

Heart Attack	Heart Bypass/Blockage	Heart Failure	Pacemaker	Stroke	Diabetes
High Blood Pressure		Emphysema	Asthma	Cancer	

WOMEN: Problems with uterus/ovaries YES NO Could you be pregnant now? YES NO

Are you on birth control now? YES NO Type _____

6. FAMILY HISTORY

a. Have any of the men in your family ever had prostate cancer? YES ____ NO ____
If yes circle: Father Grandfather Brother Uncle Cousin

b. Any other history of kidney or urinary tract disease in your family? YES ____ NO ____

c. Any other serious diseases in your family? Cancer Diabetes Heart Stroke Kidney Disease

7. SOCIAL HISTORY

a. Are you on a special diet? YES ____ NO ____ . If yes what type? _____

b. Do you use tobacco? YES ____ NO ____ Cigarettes Cigar Pipe Chew # per day _____

3. Do you drink alcohol? YES ____ NO ____ Type: _____ How much _____

4. Do you drink caffeine? YES ____ NO ____ Type: Cola Coffee Tea How much _____

6. Are you (Circle one) Single Married Divorced Widowed

7. What is your occupation? _____

8. Number of children? _____

V. REVIEW OF SYSTEMS Circle all of those below that apply.

General Weight loss/weight gain Current weight _____ Current Height _____

Eyes: Glaucoma * Blindness * Visual Disturbances

Neurological: Paralysis * Spinal Cord Injury * TIA * Multiple Sclerosis

Endocrine: Thyroid Disease * Adrenal Disease

Gastrointestinal: Nausea * Vomiting * Ulcers * Heartburn/Reflux * Gallstones * Colitis/Diverticulitis * Crohns

Cardiovascular: Leg Cramps * Irregular Heartbeat * Angina * Swollen Ankles

Varicose Veins * Blood Clots * Heart Murmur

Respiratory: Wheezing * Frequent Cough * Coughing up Blood * Shortness of Breath

Tuberculosis * Sleep Sitting Up * Pneumonia

Skin: Rash * Boils * Changing Moles

Musculoskeletal: Joint Pain * Neck Pain * Back Pain * Arthritis * Gout

Blood/ Lymphatic: Anemia * Aids/HIV * Bleed Easily * Bruise Easily * Swollen Glands/Hepatitis* Lupus

Allergy: Hay Fever * Food Allergy * Other Allergies

Ears/Nose/ Throat: Sinus * Sore Throat * Hoarse Voice * Hearing Loss

Mental: Nervous * Depression * Dementia/Alzheimer's

Cancer: Type _____ How Treated _____