

Please answer all questions completely

Date _____

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

- First & Last Name of the doctor who sent you for evaluation _____

Address _____ Phone _____

- First & Last Name of family doctor (or circle Same as above) _____

Address _____ Phone _____

Main reason you are seeing the doctor today _____

For what length of time have you had this problem? _____

Have you ever seen a urologist before? YES NO Name _____

Why did you see a urologist? _____

MEDICAL HISTORY

Height _____ Weight _____

Are you allergic to any medication YES NO Are you allergic to LATEX YES NO

Please list allergies to medications: (if none please circle HERE)

a. _____, b. _____, c. _____, d. _____.

Are you currently taking any prescription medicines? YES NO if yes please list drug name, dosage and how taken:

a. _____ d. _____

b. _____ e. _____

c. _____ f. _____

Circle Over the Counter Medications taken: Aspirin Ibuprofen Herbs Vitamins Health Food Store Medications

Have you ever had a reaction to anesthesia? YES NO

List all surgeries you have had and the date of surgery: (if none please circle HERE)

a. _____ c. _____

b. _____ d. _____

Have you ever had any of the following? (Circle all of those that apply, if none apply circle NONE)

HEAD AND NECK: sinusitis * hearing loss * glaucoma * vision loss/blindness * obstructive sleep apnea * NONE

CARDIOVASULAR: high blood pressure*heart attack*heart bypass/blockage*heart failure*pacemaker*varicose veins*blood clots* heart murmur * NONE

PULMONARY: pneumonia * tuberculosis * COPD/emphysema * asthma * NONE

NEUROLOGICAL: stroke * TIA * multiple sclerosis * spinal cord injury (level ____) * NONE

ENDOCRINE: diabetes (insulin) * diabetes (non-insulin) * thyroid disease * adrenal disease * NONE

GASTROINTESTINAL: ulcers * Chrohn’s disease * IBS * gallstones * colitis * diverticulitis * liver disease * hernia * NONE

MUSCULOSKELETAL: gout * arthritis * fractures * joint replacementv* NONE

BLOOD DISORDER/IMMUNITY: anemia * lupus *HIV/AIDS * rheumatism * NONE

ALLERGY: seasonal allergies _____ food allergies _____ * NONE

CANCER: breast * colon * brain * spine * skin * throat * lung * uterine * ovarian * other _____ * NONE

UROLOGICAL: Circle YES or NO:

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 STI YES NO
Kidney Stones YES NO Had to wear catheter YES NO Injury to urinary system YES NO Pain w/sexual intercourse YES NO

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

WOMEN: Problems with uterus/ovaries YES NO Could you be pregnant now YES NO
Are you on birth control now YES NO Type _____

REVIEW OF SYSTEMS (Circle all of those that apply, if none apply circle NONE)

GENERAL: Weight loss/weight gain * Fatigue * Sleeping difficulty * NONE

EYES: Blindness * Visual Disturbance * Tearing * Itching * Irritation * NONE

EAR,NOSE,THROAT: Difficulty swallowing*Decreased hearing*Dry mouth*Nose bleeds*Sore Throat*Sneezing*Sinus Congestion*NONE

NEUROLOGICAL: Dizziness * Weakness * Balance problems * Seizures * Fainting * Tingling * NONE

ENDOCRINE: Heat or cold intolerance * Change in appetite or thirst * Excessive sweating * NONE

GASTROINTESTINAL: Nausea * Vomiting * Ulcers * Heartburn/Reflux * Gallbladder pain * Constipation * Diarrhea * NONE

CARDIOVASCULAR: Irregular heartbeat/palpitations * Angina * Swollen ankles * NONE

RESPIRATORY: Wheezing * Frequent Cough * Coughing up Blood * Shortness of Breath * NONE

SKIN: Rash * Boils * Changing Moles * NONE

MUSCULOSKELETAL: Joint Pain * Joint swelling or redness * Neck Pain * Back Pain * Difficulty walking * Muscle stiffness *NONE

BLOOD/LYMPHATIC: Bleed Easily * Bruise Easily * Swollen Glands/Hepatitis * NONE

PSYCHIATRIC: Anxiety * Depression * Memory Loss * Stress * NONE

FAMILY & SOCIAL HISTORY Circle One – Are you Single Married Divorced Widowed

1. Have any of the men in your family ever had prostate cancer? YES NO

If yes circle: Father Grandfather Brother Uncle Cousin (Paternal or Maternal)

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

3. Any other serious diseases in your family? YES NO if yes circle: Cancer Diabetes Heart Stroke Kidney Disease

4. Family History of Kidney Stones YES NO

5. Have any of the women in your family ever had breast cancer YES NO

If yes circle: Mother Grandmother Sister Aunt Cousin (Maternal or Paternal)

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

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

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

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

10. What is your occupation? _____

11. Number of children? _____

PROVIDER'S SIGNATURE _____ **DATE** _____