Name: _____ Date:_____

Age: _____ Height: _____ Weight: _____ DOB: _____

Present Illness:

What brought you to the office today? _____.

Location of problem (abdomen, flank, etc.) _____. Severity of problem (scale of 1-10) _____.

Describe the problem (painful, painless, sharp, dull, etc.) _____.

When did you first notice the problem? _____. Is the problem constant or variable? _____.

Does anything make the problem better or worse? _____.

How long does the problem last? _____.

Does anything else occur at the same time? (nausea, fevers, etc.) _____.

Does the problem interfere with your normal function? _____.

Additional Urologic History

Have you ever had kidney X-Rays (IVP, CT, etc.) or Ultrasound? _____.

If so, which hospital were they taken at? _____.

Cystoscopic exam (look with a telescope in the bladder)? _____.

If so, please indicate results, locations and dates_____.

If male, have you ever had a PSA test (blood test for prostate cancer screening)? _____.

If so, what was the result? _____.

Do you have urinary leakage? _____.

If so, how many protective pads do you use per day? _____.

Is your leakage preceded by an urgent sensation to urinate? _____.

Is your leakage preceded by coughs, sneezes, laughing or other straining? _____.

Over the past month or so have you had a sensation of not emptying your bladder completely after you finished urination?	**Not at all**	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost Always**
Over the past month or so have you had to urinate again less than two hours after you finished urinating?	**Not at all**	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost Always**
Over the past month or so have you found that you stopped and started again several times when you urinated?	**Not at all**	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost Always**
Over the past month or so have you found it difficult to postpone urination?	**Not at all**	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost Always**
Over the past month or so have you had a weak urinary stream?	**Not at all**	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost Always**
Over the past month or so, how often have you had to push or strain to begin urination?	**Not at all**	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost Always**
Over the last month, how many times each night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	**0**	**1**	**2**	**3**	**4**	**5**

Immunization: (Ages 65 and older). Have you ever received a pneumonia vaccine? ☐ Yes ☐ No

If you answered yes please state when and where you were vaccinated _____

If you answered no, would you like to have one ordered after your appointment? ☐ Yes ☐ No

Colorectal Cancer Screening: (Ages between 50-75)

Have you received a Colonoscopy within the last 9yrs? ☐ Yes ☐ No Date: _____

If you answered no, would you like assistance in being referred to a gastroenterologist? ☐ Yes ☐ No

Infections: Please check the boxes below

☐ History of Hepatitis A ☐ History of Hepatitis B ☐ History of Hepatitis C ☐ History of Tuberculosis

Gynecological History (Females Only)

How many times have you been Pregnant? _____ How many times have you given birth? _____
How many of your deliveries were vaginal? _____

Prior Surgeries: Attach additional sheets or bring in your own list if needed

Procedure	Date Performed	Location/Facility

Family: Please check in the box below if any family members have had any of the following

	Check maternal and/or paternal	Diabetes Type I	Diabetes Type II	Heart Disease	Kidney Stones	Prostate Cancer	Indicate if your relative is Alive, Deceased, or unknown
Daughter(s)							☐ Alive / ☐ Deceased / ☐ I don't know
Son(s)							☐ Alive / ☐ Deceased / ☐ I don't know
Brother(s)							☐ Alive / ☐ Deceased / ☐ I don't know
Sister(s)							☐ Alive / ☐ Deceased / ☐ I don't know
Mother							☐ Alive / ☐ Deceased / ☐ I don't know
Father							☐ Alive / ☐ Deceased / ☐ I don't know
Grandmother(s)	☐ M / ☐ P						☐ Alive / ☐ Deceased / ☐ I don't know
Grandfather(s)	☐ M / ☐ P						☐ Alive / ☐ Deceased / ☐ I don't know

Medical: Please check the appropriate box if you have or have had any of the following:

☐ Acid Reflux (Gastroesphogeal Reflux Disease)
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Cancer
☐ Deep Vein Thrombosis (DVT)
☐ Diabetes Type I
☐ Diabetes Type II
☐ Erectile Dysfunction
☐ Gall Stones (Cholelithiasis)
☐ Glaucoma
☐ Gout
☐ Emphysema
☐ High Blood Pressure (Hypertension)
☐ High Cholesterol (Hypercholesterolemia)
☐ Heart Disease
☐ Hypothyroid
☐ Kidney Stones (Renal Calculi)
☐ Stroke (Transient Ischemic Attack/TIA)
☐ Multiple Sclerosis
☐ Myocardial Infarction
☐ Osteoporosis
☐ Seizures
☐ Ulcers
☐ Prostate Cancer (Malig Neo Prostate)

Medications: (PLEASE BRING ALL YOUR MEDICATIONS TO YOUR APPOINTMENT!)

Please include all prescriptions, **aspirin and NSAIDs** and other over-the-counter medications.

☐ Check box if you gave us consent to receive medicine updates from your pharmacy? Please refer to the consent form.

Medication Name	Strength/Dosage	Special Instructions

→

Allergies: Please list all your allergies If none or unknown please check the correct box

Food Allergies	**Food Name**	**Type of Reaction you had**
☐ None		
☐ Unknown		

Drug Allergies	**Drug Name (Be as specific as possible)**	**Type of Reaction you had**
☐ None		
☐ Unknown		

Environmental Allergies	**Name**	**Type of Reaction you had**
☐ None		
☐ Unknown		
☐ Seasonal -		

Social:

Smoking History

☐ Never Smoked	☐ I quit smoking	☐ I smoke everyday	☐ I've been smoking
☐ Never smoked/chewed tobacco	☐ Less than 5yrs ago	☐ 0-10 cigarettes	☐ 1yr ☐ 20yrs
☐ I smoke some days	☐ 5-10yrs ago	☐ 11-20 cigarettes	☐ 2yrs ☐ 25yrs
☐ I Currently smoke tobacco	☐ Over 10yrs ago	☐ 21-30 cigarettes	☐ 3yrs ☐ 40yrs
☐ I use smokeless tobacco			☐ 15yrs ☐ 45yrs

Alcohol History	**Number of Drinks/Day**		**/ Years of Drinking**			
☐ Never Drink	☐ 1-4 drinks/wk	☐ 14 drinks/wk	☐ 0-1	☐ 5	☐ 20	☐ 35
☐ Quit this year	☐ 7 drinks/wk	☐ More than 2 drinks/day	☐ 2	☐ 10	☐ 25	☐ 40
☐ Currently Drink	☐ 10 drinks/wk	☐ Drink rarely	☐ 3	☐ 15	☐ 30	☐ 45+

History

Review of Systems that are <u>CURRENT</u> (Negative Unless Checked)

Constitutional
- ☐ Night sweats
- ☐ Recent Fevers
- ☐ Weight Loss

Eyes
- ☐ Blind Spots
- ☐ Double Vision

Ears/Nose/Throat/Neck
- ☐ Neck Lumps

Cardiovascular
- ☐ Chest pain
- ☐ Fainting
- ☐ Leg swelling
- ☐ Palpitations

Respiratory
- ☐ Blood in sputum
- ☐ Productive cough
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal
- ☐ Bowel disease/polyps
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Jaundice
- ☐ Red or tarry stool
- ☐ Vomiting

Genitourinary/Nephrology
- ☐ Painful urination
- ☐ Impaired erections
- ☐ Blood in urine
- ☐ Diminished libido
- ☐ Kidney stones
- ☐ Urine infections
- ☐ Flank Pain

Musculoskeletal
- ☐ Muscle weakness
- ☐ Osteoporosis
- ☐ Painful joints

Dermatologic
- ☐ Rash

Neurologic
- ☐ Severe Headaches
- ☐ Seizures

Psychiatric
- ☐ Depression

Endocrine
- ☐ Heat or cold intolerance
- ☐ Excessive thirst

Hematologic/lymphatic
- ☐ Bleeding tendency

Allergy/Immunology
- ☐ Seasonal Allergies

Please describe any of the above conditions here:_____