

**IN YOUR OWN WORDS, TELL US WHAT CONDITION BRINGS YOU TO THE UROLOGIST:**

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**PAST MEDICAL HISTORY** \_\_\_\_\_ **UNREMARKABLE**

(MARK AN "X" BY ANY ILLNESSES YOU HAVE HAD; IF NONE, CHECK "UNREMARKABLE" ABOVE)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> ARTHRITIS              | <input type="checkbox"/> GERD/ACID REFLUX      | <input type="checkbox"/> PARALYSIS                |
| <input type="checkbox"/> BLOOD CLOTS/THROMBOSIS | <input type="checkbox"/> HEART DISEASE         | <input type="checkbox"/> PROSTATE PROBLEMS        |
| <input type="checkbox"/> BLOOD TRANSFUSIONS     | <input type="checkbox"/> HEART ATTACK: YES NO  | <input type="checkbox"/> CANCER _____ BPH         |
| <input type="checkbox"/> BROKEN BONES           | <input type="checkbox"/> HERNIA                | <input type="checkbox"/> PSYCHIATRIC ILLNESS      |
| <input type="checkbox"/> WHICH _____            | <input type="checkbox"/> LOCATION: _____       | <input type="checkbox"/> TYPE: _____              |
| <input type="checkbox"/> CANCER                 | <input type="checkbox"/> HEPATITIS B           | <input type="checkbox"/> SEXUAL DYSFUNCTION       |
| <input type="checkbox"/> LOCATION _____         | <input type="checkbox"/> HEPATITIS C           | <input type="checkbox"/> STROKE                   |
| <input type="checkbox"/> _____                  | <input type="checkbox"/> HIGH BLOOD PRESSURE   | <input type="checkbox"/> THYROID PROBLEMS         |
| <input type="checkbox"/> CHOLESTEROL            | <input type="checkbox"/> HIV                   | <input type="checkbox"/> HIGH _____ LOW           |
| <input type="checkbox"/> COLONIC POLYPS         | <input type="checkbox"/> INCONTINENCE OF URINE | <input type="checkbox"/> TUBERCULOSIS/TB          |
| <input type="checkbox"/> COPD                   | <input type="checkbox"/> KIDNEY DISEASE        | <input type="checkbox"/> _____ ULCERS             |
| <input type="checkbox"/> DIABETES               | <input type="checkbox"/> KIDNEY INFECTIONS     | <input type="checkbox"/> URINARY TRACT INFECTIONS |
| <input type="checkbox"/> INSULIN: YES NO        | <input type="checkbox"/> KIDNEY STONES         | <input type="checkbox"/> AVERAGE #/YEAR: _____    |
| <input type="checkbox"/> GALLSTONES             | <input type="checkbox"/> LUNG PROBLEMS         | <input type="checkbox"/> VASCULAR DISEASE         |

OTHER: \_\_\_\_\_

**PAST SURGICAL HISTORY** \_\_\_\_\_ **UNREMARKABLE**

(MARK AN "X" BY ANY SURGERIES YOU HAVE HAD; IF NONE, CHECK "UNREMARKABLE" ABOVE)

HAVE YOU HAD:

- |  | YEAR  |   | YEAR  |
|--|-------|---|-------|
| <input type="checkbox"/> APPENDECTOMY                  | _____ | <input type="checkbox"/> KIDNEY SURGERY     | _____ |
| <input type="checkbox"/> BACK SURGERY                  | _____ | <input type="checkbox"/> TYPE: _____        | _____ |
| <input type="checkbox"/> BLADDER SUSPENSION            | _____ | <input type="checkbox"/> ORTHOPEDIC SURGERY | _____ |
| <input type="checkbox"/> CARDIAC SURGERY               | _____ | <input type="checkbox"/> TYPE: _____        | _____ |
| <input type="checkbox"/> CAROTID SURGERY               | _____ | <input type="checkbox"/> PACEMAKER          | _____ |
| <input type="checkbox"/> CATARACT REMOVAL              | _____ | <input type="checkbox"/> SCROTAL SURGERY    | _____ |
| <input type="checkbox"/> C-SECTION                     | _____ | <input type="checkbox"/> TYPE: _____        | _____ |
| <input type="checkbox"/> GALLBLADDER                   | _____ | <input type="checkbox"/> STONE SURGERY      | _____ |
| <input type="checkbox"/> _____ OPEN _____ LAP          | _____ | <input type="checkbox"/> TYPE: _____        | _____ |
| <input type="checkbox"/> HERNIA REPAIR                 | _____ | <input type="checkbox"/> THYROID SURGERY    | _____ |
| <input type="checkbox"/> SIDE _____ TYPE _____         | _____ | <input type="checkbox"/> TONSILLECTOMY      | _____ |
| <input type="checkbox"/> HYSTERCTOMY                   | _____ | <input type="checkbox"/> TUBAL LIGATION     | _____ |
| <input type="checkbox"/> _____ ABDOMINAL _____ VAGINAL | _____ | <input type="checkbox"/> TURP               | _____ |
| <input type="checkbox"/> OVARIES REMOVED:              | _____ | <input type="checkbox"/> URETHRAL DILATION  | _____ |
| <input type="checkbox"/> _____ RIGHT _____ LEFT        | _____ | <input type="checkbox"/> VASCULAR SURGERY   | _____ |
|  |       | <input type="checkbox"/> VIU                | _____ |

OTHER: \_\_\_\_\_

ANESTHESIA RECEIVED: \_\_\_\_\_ GENERAL \_\_\_\_\_ SPINAL \_\_\_\_\_ EPIDURAL  
 \_\_\_\_\_ IV SEDATION \_\_\_\_\_ LOCAL

\_\_\_\_\_ HAVE YOU HAD ANY ADVERSE REACTIONS TO ANY ANESTHETIC? (LIST)

PATIENT: \_\_\_\_\_

PT. NUMBER: \_\_\_\_\_

# REVIEW OF SYSTEMS

\_\_\_\_\_ *UNREMARKABLE*

(MARK AN "X" ONLY FOR THOSE WITH WHICH YOU HAVE HAD PROBLEMS IN THE LAST 2-3 MONTHS, IF NONE, CHECK "UNREMARKABLE" ABOVE)

## CONSTITUTIONAL

- \_\_\_\_\_ LOSS OF WEIGHT
- \_\_\_\_\_ LACK OF APPETITE
- \_\_\_\_\_ FEVER

## EYES

- \_\_\_\_\_ GLAUCOMA
- \_\_\_\_\_ CHANGE IN VISUAL FIELD

## ENT

- \_\_\_\_\_ EARS
- \_\_\_\_\_ MOUTH
- \_\_\_\_\_ THROAT
- \_\_\_\_\_ SINUSES

## RESPIRATORY

- \_\_\_\_\_ COUGHING
- \_\_\_\_\_ SHORTNESS OF BREATH
- \_\_\_\_\_ SPITTING UP BLOOD
- \_\_\_\_\_ INFECTIONS/PNEUMONIA

## GENITOURINARY

- \_\_\_\_\_ WEAK URINARY STREAM
- \_\_\_\_\_ BLOOD IN URINE
- \_\_\_\_\_ INVOLUNTARY LOSS OF URINE
- \_\_\_\_\_ BACK/FLANK PAIN
- \_\_\_\_\_ CHANGE IN SEXUAL FUNCTION
- \_\_\_\_\_ FREQUENCY OF URINATION
- \_\_\_\_\_ EXTREME URGENCY TO URINATE
- \_\_\_\_\_ NIGHT TIME NEED TO URINATE
- \_\_\_\_\_ STRAINING TO URINATE

## SKIN

- \_\_\_\_\_ CHANGE IN COLOR OF A MOLE
- \_\_\_\_\_ BLEEDING FROM A MOLE

## CARDIOVASCULAR

- \_\_\_\_\_ CHEST PAIN/ANGINA
- \_\_\_\_\_ ANKLE SWELLING
- \_\_\_\_\_ LEG (CALF) PAIN
- \_\_\_\_\_ BLOOD CLOTS

## NEUROLOGICAL

- \_\_\_\_\_ NUMBNESS
- \_\_\_\_\_ WEAKNESS
- \_\_\_\_\_ PARALYSIS

## GASTROINTESTINAL

- \_\_\_\_\_ ABDOMINAL PAIN
- \_\_\_\_\_ NAUSEA
- \_\_\_\_\_ VOMITING
- \_\_\_\_\_ DIARRHEA
- \_\_\_\_\_ CONSTIPATION
- \_\_\_\_\_ BLOOD IN STOOLS
- \_\_\_\_\_ RECENT CHANGE IN STOOL SIZE/CALIBER

## PSYCHIATRIC/EMOTIONAL

- \_\_\_\_\_ ANXIOUS OR DEPRESSED
- \_\_\_\_\_ JOB-RELATED STRESS
- \_\_\_\_\_ MARITAL STRESS
- \_\_\_\_\_ FINANCIAL-RELATED STRESS

# MEDICATIONS

(PLEASE LIST ALL MEDICATIONS WHICH YOU TAKE IN THE SPACE BELOW, IF NONE, THEN PLEASE CHECK THE SPACE "NONE" BELOW)

MEDICATION & DOSAGE

\_\_\_\_\_ NONE

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT: \_\_\_\_\_

PT. NUMBER: \_\_\_\_\_

# ALLERGIES \_\_\_\_\_ *NO KNOWN DRUG ALLERGY*

(MARK "X" WHERE APPROPRIATE; IF NONE, THEN MARK "NO KNOWN DRUG ALLERGY")

- |  |   |                                    |
|--|---|------------------------------------|
| <input type="checkbox"/> PENICILLIN      | <input type="checkbox"/> CODEINE        | <input type="checkbox"/> ASPIRIN   |
| <input type="checkbox"/> SULFA           | <input type="checkbox"/> MORPHINE       | <input type="checkbox"/> CELEBREX  |
| <input type="checkbox"/> MACRODANTIN     | <input type="checkbox"/> HYDROCODONE    | <input type="checkbox"/> VIOXX     |
| <input type="checkbox"/> CIPRO           | <input type="checkbox"/> DEMEROL        | <input type="checkbox"/> IBUPROFEN |
| <input type="checkbox"/> LEVAQUIN        | <input type="checkbox"/> DARVOCET       | <input type="checkbox"/> NAPROSYN  |
| <input type="checkbox"/> ERYTHROMYCIN    | <input type="checkbox"/> TORADOL        |                                    |
| OTHER ANTIBIOTIC:                        |   |                                    |
| _____                                    | <input type="checkbox"/> LATEX          |                                    |
| <input type="checkbox"/> IODINE          | <input type="checkbox"/> TETANUS TOXOID |                                    |
| <input type="checkbox"/> BETADINE        | <input type="checkbox"/> FOODS: _____   |                                    |
| <input type="checkbox"/> PHISOHEX        | <input type="checkbox"/> OTHER: _____   |                                    |
| <input type="checkbox"/> IVP OR XRAY DYE |   |                                    |

## SOCIAL HISTORY

### EDUCATION:

### HABITS:

LAST GRADE COMPLETED: \_\_\_\_\_

DO YOU:

COLLEGE/# OF YEARS: \_\_\_\_\_

DEGREES: \_\_\_\_\_

SMOKE: YES NO #/DAY: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

DRINK: YES NO AMOUNT/WEEK: \_\_\_\_\_

## FAMILY HISTORY \_\_\_\_\_ *UNREMARKABLE*

(MARK "X" TO INDICATE YES; IF NONE APPLY, THEN CHECK "UNREMARKABLE" ABOVE)

- |  |  |
|--|--|
| <input type="checkbox"/> ALZHEIMER'S DISEASE | <input type="checkbox"/> LIVER DISEASE             |
| <input type="checkbox"/> BREAST CANCER       | <input type="checkbox"/> MENTAL ILLNESS            |
| <input type="checkbox"/> COLON CANCER        | <input type="checkbox"/> PROSTATE CANCER           |
| <input type="checkbox"/> COLON POLYPS        | <input type="checkbox"/> SICKLE CELL TRAIT/DISEASE |
| <input type="checkbox"/> DIABETES            | <input type="checkbox"/> STROKE                    |
| <input type="checkbox"/> GLAUCOMA            | <input type="checkbox"/> THYROID DISEASE           |
| <input type="checkbox"/> HEART DISEASE       | <input type="checkbox"/> OTHER: _____              |
| <input type="checkbox"/> HYPERTENSION        | _____  |
| <input type="checkbox"/> KIDNEY DISEASE      | _____  |

## GYNECOLOGIC HISTORY (FEMALES ONLY)

(MARK "X" TO INDICATE YES WHERE APPROPRIATE)

### MENSTRUAL HISTORY:

AGE OF ONSET: \_\_\_\_\_ CYCLE: \_\_\_\_\_ REGULAR FLOW: \_\_\_\_\_ HEAVY  
USUAL DURATION: \_\_\_\_\_ DAYS \_\_\_\_\_ IRREGULAR \_\_\_\_\_ MEDIUM  
\_\_\_\_\_ CRAMPS \_\_\_\_\_ PAINFUL INTERCOURSE \_\_\_\_\_ VAGINAL DRYNESS \_\_\_\_\_ LIGHT

### PREGNANCIES: (WRITE IN NUMBER WHERE APPROPRIATE)

PREGNANCIES: \_\_\_\_\_ ABORTIONS: \_\_\_\_\_  
LIVE BIRTHS: \_\_\_\_\_ MISCARRIAGES: \_\_\_\_\_  
STILLBORNS: \_\_\_\_\_ C-SECTIONS: \_\_\_\_\_  
ANY COMPLICATIONS WITH PREGNANCY OR DELIVERY: \_\_\_\_\_

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

X \_\_\_\_\_ (PATIENT SIGNATURE)

I HAVE REVIEWED THIS INFORMATION \_\_\_\_\_ (Physician Initials)