**Patient Name:**

**Date**:

**Main Reason for Your Visit:**

**Medication List (Including over the counter medications):**

**Allergy to Medications:**

**Reaction:**

**PAST MEDICAL HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| DIABETES | YES | NO | EMPHYSEMA/COPD | YES | NO |
| HIGH BLOOD PRESSURE | YES | NO | PNEUMONIA | YES | NO |
| STROKES | YES | NO | DEPRESSION/BIPOLAR | YES | NO |
| HEART DISEASE/HEART ATTACK | YES | NO | MENTAL ILLNESS | YES | NO |
| KIDNEY STONES | YES | NO | DEMENTIA/ALZHEIMER’S ETC. | YES | NO |
| THYROID DISEASE | YES | NO | ULCER | YES | NO |
| SEIZURES | YES | NO | LIVER DISEASE | YES | NO |
| BLEEDING DISORDER | YES | NO | HIGH CHOLESTEROL | YES | NO |
| SEXUALLY TRANSMITTED DISEASE | YES | NO | IRRITABLE BOWEL SYNDROME | YES | NO |
| TUBERCULOSIS | YES | NO | GLAUCOMA (narrow angle) (wide angle) | YES | NO |
| RHEUMATIC FEVER | YES | NO | DIABETES | YES | NO |
| ASTHMA | YES | NO | CANCER | YES | NO |
| ANXIETY | YES | NO | ~CANCER TYPE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | YES | NO |

 **PAST SURGICAL HISTORY**

|  |  |  |
| --- | --- | --- |
| Heart BypassInguinal Hernia: Left Right BothUmbilical Hernia Repair | AppendectomyGallbladder: Open LaparoscopicVasectomy | Hysterectomy Abdominal VaginalOvaries Removed: Left Right Both |
| Joint Replacement(s):  |

 **FAMILY HISTORY: *(Please circle Medical Problems that run in your family)*** NONE PROSTATE CANCER
BLADDER CANCER KIDNEY CANCER KIDNEY STONES HEART DISEASE DIABETES STROKES

OTHER:

 **FAMILY HISTORY: *(Please circle Medical Problems that run in your family)*** NONE PROSTATE CANCER
BLADDER CANCER KIDNEY CANCER KIDNEY STONES HEART DISEASE DIABETES STROKES

OTHER:



**PATIENT SOCIAL HISTORY**

USE OF TOBACCO: Never  Quit/Year: Yes, Packs/Day: Other:

RECREATIONAL DRUG USE: Never Quit Yes, Type & Frequency:

MARITAL STATUS: Single Married Widowed Separated Divorced

USE OF ALCOHOL: Never Quit Rarely Occasionally ModerateHeavyAmount:

OCCUPATION: Full-time Part-time Retired Disabled Job Description:

**REVIEW OF SYSTEMS**

 **HISTORY OF PRESENT ILLNESS *(Please circle and/or answer the following questions)***

**Please circle YES or NO to the following Questions:**

YES NO Pain or burning with urination?
YES NO Blood in urine at any time?
YES NO Difficulty starting urination?
YES NO Inability to hold urine (Incontinence)?
YES NO Kidney/Bladder Infection?
YES NO Kidney Stones?
YES NO Bedwetting?
YES NO Urinating too frequently?
YES NO Awakening at night to urinate more than once?
If yes, how many times?
YES NO Have you been to a urologist before?
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
YES NO Have you had bladder or kidney x-rays before?
YES NO NA Are your periods normal?
YES NO NA Recent vaginal discharge?

**Location of the problem:**Abdomen Back Leg Other:

**On a scale of 1-10, with 10 being the most severe, circle the number that best describes the severity of your problem(s):** 1 2 3 4 5 6 7 8 9 10

**When did you first notice the problem?**\_\_\_\_\_\_ days ago \_\_\_\_\_\_ weeks ago month(s) ago
Other:

**Is there anything else occurring at the same time?**
YES NO If yes, please explain.
Nausea Vomiting Fevers Chills Headaches Rash
Other:

Can you qualify your problem/pain?
Dull then sharp Very sharp then leaves Always there
Other:

**Does the problem interfere with your normal activity/functions?**
YES NO If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Signature: Date:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| FEVER/CHILLS/NIGHT SWEATS  | YES | NO |  | HEARTBURN/DIFFICULTY SWALLOWING | YES | NO |
| DIZZY LIGHTHEADED | YES | NO | ABDOMINAL DISCOMFORT | YES | NO |
| WEIGHT CHANGE | YES | NO | NAUSEA/VOMITING | YES | NO |
| ALLERGIES/COLD SYMPTOMS | YES | NO | BLOODY/BLACK STOOLS | YES | NO |
| VISUAL PROBLEMS | YES | NO | RASHES | YES | NO |
| HEADACHES | YES | NO | HEARTBURN/DIFFICULTY SWALLOWING | YES | NO |
| NECK/BACK PAIN | YES | NO | URINARY PROBLEMS | YES | NO |
| COUGH | YES | NO | VAGINAL/PENILE DISCHARGE | YES | NO |
| SHORTNESS OF BREATH | YES | NO | INCREASED THIRST/URINATION | YES | NO |
| CHEST DISCOMFORT | YES | NO | DEPRESSION/ANXIETY | YES | NO |
| PALPITATIONS | YES | NO | INSOMNIA | YES | NO |