Urology Associates Medical Group
A Division of U.S.S.C.

Patient Name: _____ **Date:** _____

Referred by: _____ **Primary Doctor:** _____ **Pharmacy #**_____
(NAME and/or LOCATION)

Why are you seeing the physician today? _____

My Main Problems Are:
◊ Blood in urine ◊ Bladder Infection ◊ Bladder Pain ◊ Dropped Bladder ◊ Kidney Stones ◊ Interstitial Cystitis
◊ Leak Urine ◊ Overactive Bladder ◊ Other _____

Allergies: _____

Medications:
_____
_____
_____

Surgical History: ◊ Appendectomy ◊ Back R/L side ◊ Hip R/L side ◊ Knee R/L side ◊ Cystoscopy ◊ Gallbladder
◊ Heart Bypass ◊ Kidney Stones ◊ Lithotripsy ◊ Sling (TVT) ◊ Hysterectomy ◊ Vaginal Deliveries #_____
◊ C-Section # _____ ◊ Other _____

Medical History: ◊ Diabetes ◊ Emphysema ◊ Heart Attack ◊ Heart Murmur ◊ Hepatitis ◊ High Blood Pressure
◊ Parkinson's ◊ Strokes ◊ High Cholesterol ◊ Thyroid Problem ◊ Menopause ◊ **Cancer:** _____
◊ Other _____

Family History: ◊ Kidney Stones ◊ Kidney Cancer ◊ Heart Disease ◊ Other _____

Social History: (circle one)
Marital Status: Single Married Divorced Widowed Separated **Daily Caffeine Intake:** 0 1 2 3 4+
Smoke: Yes How long? _____ Packs per day? _____ **Alcohol:** Yes Drinks per week? _____
No More When did you quit? _____ No More When did you quit? _____
Never Never

History of Blood Transfusion: YES NO

My Current Symptom(s) are:

General/Constitutional:	◊ Fever	◊ Weight Loss	◊ Chills
Eyes:	◊ Blurry Vision	◊ Double Vision	◊ Cataracts
Ears, Nose, Mouth, Throat:	◊ Hearing Loss	◊ Nasal Stuffiness	◊ Sore Throat
Cardiovascular:	◊ Chest Pains	◊ Swollen Ankles	◊ Irregular Heartbeat
Respiratory:	◊ Shortness of Breath	◊ Wheezing	◊ Chronic Cough
Gastrointestinal:	◊ Abdominal Pain	◊ Nausea/Vomiting	◊ Change In Bowels
Genitourinary:	◊ Incontinence	◊ Painful Urination	◊ Blood in Urine
Musculoskeletal:	◊ Chronic Back Pain	◊ Chronic Neck Pain	◊ Sore Muscles
Integumentary/Skin:	◊ Rash	◊ Persistent Itching	◊ Skin Cancer History
Neurologic:	◊ Numbness	◊ Tingling	◊ Dizziness
Hematologic/Lymphatic:	◊ Swollen Glands	◊ Abnormal Bleeding	◊ Transfusion History

Urinary Symptom(s) are: ◊ Frequency ◊ Urgency ◊ Leakage ◊ Abdominal Pain ◊ Straining ◊ Bladder Pain
◊ Pain on R/L side ◊ Not Emptying Bladder ◊ Urinating at night # _____

OFFICE USE ONLY:

BP: _____ Temp: _____ Height: _____