

**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:

- Enlarge Prostate High PSA Prostate Infection Prostate Cancer Lump on Testicle Erectile Dysfunction
 Infertility Kidney Stones Blood in Urine Bladder Infection Urinary Incontinence Bladder Cancer
 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 Prostate Biopsy Prostate Seed Prostate Surgery
 Other _____

Medical History: Diabetes Emphysema Heart Attack Heart Murmur Hepatitis Kidney Stone Strokes
 High Blood Pressure Parkinson's Cholesterol **Cancer:** Prostate Kidney Other _____

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

Social History:

Marital Status: Single Married Divorced Widowed Separated

Smoke: Yes How long? _____ Packs per day? _____
 No More When did you quit? _____
 Never

Daily Caffeine Intake: 0 1 2 3 4+

Alcohol: Yes Drinks per week? _____
 No More When did you quit? _____
 Never

History of Blood Transfusion: YES NO

My Current Symptom(s) are:

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

Urinary Symptom(s) are: Frequency Intermittency Weak Stream Straining Testicular Pain
 Bladder Pain Pain on R/L side Incomplete Emptying Urinating at night # _____

OFFICE USE ONLY:

BP: _____ Temp: _____ Height: _____