REASON FOR YOUR VISIT	

PRIOR EVALUATION BY UROLOGIST? (when, reason, and by whom)	

MEDICAL HISTORY **(Please check all that apply and note how long the problem has existed)**

☐ Abnormal heart rhythm / Atrial fibrillation	☐ Esophageal reflux	☐ Multiple sclerosis
☐ Anemia (Low blood count)	☐ Glaucoma	☐ Parkinson's Disease
☐ Arthritis	☐ Gout	☐ Sexually transmitted disease: __________
☐ Asthma / emphysema / COPD	☐ Heart attack / coronary artery disease	☐ Stroke / TIA
☐ Autoimmune or connective tissue	☐ Heart failure	☐ Thyroid disease
☐ Bleeding / clotting disorders	☐ High blood pressure	☐ Tuberculosis
☐ Blood clots in the legs or lungs	☐ High cholesterol	☐ Peptic ulcer disease
☐ Cancer: ___________________________	☐ Hepatitis	☐ Urinary tract infections
☐ Colitis or inflammatory bowel disease	☐ HIV infection / AIDS	☐ Other: ____________________________
☐ Depression or anxiety	☐ Infertility	☐ Other: ____________________________
☐ Diabetes	☐ Kidney disease / Renal failure	☐ Other: ____________________________
☐ Diverticulosis or Diverticulitis	☐ Kidney stones / Bladder stones	☐ Other: ____________________________

SURGICAL HISTORY **(Please check all that apply and circle the specific associated procedures. Pls include dates if possible)**

☐ Appendectomy	☐ Gallbladder removal: open vs laparoscop	☐ Pacemaker placement
☐ Bladder tumor removal (Transurethral)	☐ Hernia repair: ______________________	☐ Tonsillectomy
☐ Bladder removal (Total Cystectomy)	☐ Hysterectomy: open / vaginal / laparosco	☐ Tubal ligation
☐ Breast surgery	☐ Joint surgery: ______________________	☐ Vaginal prolapse repair
☐ Caesarian section: how many? _______	☐ Urine leakage surgery: _______________	☐ Other: ____________________________
☐ Coronary stent or bypass (CABG)	☐ Kidney stone surgery: _______________	☐ Other: ____________________________
☐ Colon surgery (Colectomy)	☐ Kidney surgery: total or partial removal	☐ Other: ____________________________
☐ Eye surgery: _______________________	☐ Ovary removal: LT RT BL	☐ Other: ____________________________

FAMILY HISTORY **Please note relation (parent, sibling, or offspring)**

☐ Abnormal bleeding/bruising: __________	☐ Breast cancer:______________________	☐ Kidney cancer: _____________________
☐ Genetic diseases: __________________	☐ Ovarian cancer: ______________________	☐ Problems with anesthesia: ____________
☐ Kidney stones: _____________________	☐ Uterine cancer: ______________________	☐ Other: ____________________________

SOCIAL HISTORY / HEALTH HABITS

Marital Status Single Mar Wid Div Sep	Whom do you live with?	Are you currently sexually active?

SMOKING STATUS	☐ Current	☐ Former	☐ Never a Smoker
	☐ ____________ packs/day	☐ How many years? ________	☐ Quit ___________ yrs ago

ALCOHOL USE : ☐ No ☐ Yes: How many drinks / wk?	CAFFEINE USE : ☐ No ☐ Yes: How many drinks / day?

CURRENT OR FORMER OCCUPATION:

OBSTETRIC HISTORY	Total # of Pregnancies: _____	# of Live Births: ________	Wt of Largest Baby: ________
# of Vaginal Delivery: ________	# of C-section: ________	# of Abortions: ________	
Any delivery complications? Please describe:			
GYNECOLOGICAL HISTORY	Date of Last Period: ________	Date of Last Pap: ___________	Using birth control?
Are you in menopause? ☐ No ☐ Yes: When? ______________		Are you on hormonal therapy? ☐ No ☐ Yes: _______________	

REVIEW OF SYSTEMS **Please check any symptoms that you have had in the last 6 months**

URINARY

- ☐ Frequency: how many times during the day do you urinate? ____
- ☐ Urgency: if yes, do you ever leak related to a strong urge? _____
- ☐ Nocturia: how many times at night do you wake to urinate? ____
- ☐ Leakage of urine with straining, coughing, exercise? __________
- ☐ Pads for urine leakage? If yes, how many per day? ___________
- ☐ Straining to void
- ☐ Intermittent stream
- ☐ Slow / decreased stream
- ☐ Incomplete bladder emptying
- ☐ Pain with full bladder
- ☐ Urethral discharge
- ☐ Blood in the urine
- ☐ Burning with urination
- ☐ Pelvic pain
- ☐ Flank / Kidney pain

GENERAL

- ☐ Fevers
- ☐ Chills
- ☐ Weight loss
- ☐ Poor appetite
- ☐ Fatigue

EENT

- ☐ Dry eyes
- ☐ Dry mouth
- ☐ Hearing loss
- ☐ Recent vision changes

CARDIOVASCULAR

- ☐ Racing heart or palpitations
- ☐ Chest pain
- ☐ Calf pain with exercise
- ☐ Swelling of legs

Can you walk > 2 blocks or 2 flights without shortness of breath? ☐ Yes ☐ No

RESPIRATORY

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Nausea / Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Changes in bowel habits
- ☐ Blood in the stools
- ☐ Stool incontinence

GYNECOLOGIC

- ☐ Irregular or heavy periods
- ☐ Bleeding since menopause
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Vaginal itching or discomfort
- ☐ Vaginal bulge / falling organs

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Back pain
- ☐ Bone pain
- ☐ Muscle pain
- ☐ Sciatica

SKIN / BREAST

- ☐ Loss or growth of hair
- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ Breast swelling
- ☐ Nipple discharge

NEUROLOGICAL

- ☐ Tremor
- ☐ Dizziness
- ☐ Numbness in body part
- ☐ Headaches
- ☐ Incoordination
- ☐ Tingling / Pins and needles
- ☐ Paralysis

PSYCHOSOCIAL

- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Anxiety
- ☐ Difficulty sleeping
- ☐ Excessively high stress
- ☐ Memory problems
- ☐ Psychiatric care

LYMPHATIC / ENDOCRINE

- ☐ Lymph node tenderness
- ☐ Swollen glands
- ☐ Excessive thirst
- ☐ Intolerance to hot / cold
- ☐ Lack of energy or strength
- ☐ Hot flashes

ANY KNOWN DRUG ALLERGIES? **If so, please list drug and type of reaction it caused (rash, swelling, difficulty breathing, etc)**

ANY ALLERGY TO LATEX (RUBBER PRODUCTS)? ☐ **No** ☐ **Yes - Describe: ____________________**

ANY ALLERGY TO SHELLFISH OR "IODINE DYE" (for X-ray studies)? ☐ **No** ☐ **Yes - Describe: ____________________**

CURRENT MEDICATIONS Please include prescriptions, vitamins, supplements, and over-the-counter medication ☐ NONE