Primary Care Physician: _____

Preferred Pharmacies: (1) Name _____ Location _____

(2) Name _____ Location _____

ALLERGIES

☐ No Known Allergies

Medication/Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS

☐ No Medications

Medication Name	Dose	# of Pills/Sprays/Drops and Times per Day	Over the Counter	Prescription

Name _____ DOB _____/_____/_____ Date _____/_____/_____

UROLOGY PAST HISTORY (Male)

Past Medical History Check all that apply.

- ☐ None
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Enlarged Prostate
- ☐ Cancer _____
- ☐ Stroke
- ☐ Chronic UTIs
- ☐ Liver Disease
- ☐ Heart failure
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular Disease
- ☐ GERD (reflux)
- ☐ Gout
- ☐ Lupus
- ☐ Hepatitis C
- ☐ Hypercholesterolemia
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Migraine headaches
- ☐ Heart attack
- ☐ Neurologic disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcer disease
- ☐ Peripheral Vascular Disease
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Thyroid Disease
- ☐ Kidney Stones
- ☐ Valvular Heart Disease
- ☐ _____
- ☐ _____

Past Surgical History Check all that apply and write in approximate year of surgery.

- ☐ None
- ☐ Adrenalectomy
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Bladder Augmentation (enlarge bladder with bowel)
- ☐ CABG (heart bypass)
- ☐ Galbladder Removal
- ☐ Colectomy (colon removal)
- ☐ Colon Surgery
- ☐ Coronary (heart) Stent
- ☐ Cystectomy (removal of bladder)
- ☐ Cystoscopy
- ☐ ESWL (lithotripsy of stones)
- ☐ Gastric Bypass
- ☐ Green Light PVP
- ☐ Hernia Repair
- ☐ Hip Replacement (L / R)
- ☐ Hydrocele Repair
- ☐ Knee Replacement (L / R)
- ☐ Laparoscopy
- ☐ Liver Biopsy
- ☐ Nephrectomy (L / R kidney removal)
- ☐ Pacemaker
- ☐ Percutaneous nephrolithotomy
- ☐ Ureteroscopy – stone removal
- ☐ Ureteroscopy – stent

Other surgery not listed:

- ☐ _____
- ☐ _____
- ☐ Circumcision
- ☐ Removal of Testicle (L / R)
- ☐ Penile Prosthesis (implant)
- ☐ Prostate Biopsy
- ☐ Prostate Brachytherapy
- ☐ Prostatectomy
- ☐ Spermatocelectomy
- ☐ TURP
- ☐ Varicocele Ligation
- ☐ Vasectomy
- ☐ Microwave of Prostate

Name _____ DOB _____/_____/_____ Date _____/_____/_____

FAMILY HISTORY

Please check the appropriate boxes next to any applicable conditions and corresponding immediate family members.

☐ Adopted/family history not known

	Mother	Father	Sister	Brother	Other		Mother	Father	Sister	Brother	Other
Alive & Well						Hyperlipidemia (high cholesterol)					
Blood Disease						Hypertension					
BPH (enlarged prostate)						Inflammatory bowel disease					
Cancer Type: _____ _____						Migraines					
Stroke						Renal Failure					
Coronary artery disease						Seizure disorder					
Diabetes						Thyroid disorder					
Eczema						Urinary tract infections					
Gout						Kidney Stones					
Hearing Impairment						Other _____					

☐ Prostate Cancer, relation? _____

☐ Kidney Cancer, relation? _____

Name _____ DOB _____/_____/_____ Date _____/_____/_____

SOCIAL HISTORY

Birthplace _____ **Primary Language _____**

Highest Level of Education

- ☐ None
- ☐ Home-Schooling
- ☐ Elementary School
- ☐ High School
- ☐ GED
- ☐ Some College
- ☐ College Graduate
- ☐ Grad School
- ☐ Trade School
- ☐ Technical School
- ☐ Post-College
- ☐ Medical School
- ☐ Law School
- ☐ Other

Degree obtained

- ☐ Associate
- ☐ Bachelor
- ☐ Dental doctorate
- ☐ Law
- ☐ Master
- ☐ Medical
- ☐ Nursing
- ☐ Pharmacy
- ☐ Veterinary
- ☐ Other _____

Occupation _____

Employment Status

- ☐ Full-Time
- ☐ Part-Time
- ☐ Self-Employed
- ☐ Unemployed
- ☐ Retired
- ☐ Laid Off
- ☐ Disabled
- ☐ Private Disability
- ☐ Social Security Disability

Military Experience

☐ No

Branch: _____

Current status:

- ☐ Active Duty
- ☐ Reserves
- ☐ Discharged
- ☐ Retired

Tobacco Use

- ☐ Never
- ☐ Former (Year quit _____)
- ☐ Currently Using Tobacco Products
- ☐ Cigarettes => ____ packs per day for ___ years
- ☐ Chewing tobacco => _____ cans/pouches per day for _____ years
- ☐ Cigars => _____# per day for ____ years
- ☐ Pipe => _____ # per day for ____ years

Alcohol Use

Type _____ Amount _____ Frequency (How often?) _____

_____ _____ _____

Caffeine Use

Type _____ Amount _____ Frequency (How often?) _____

_____ _____ _____

_____ _____ _____

Name _____ DOB _____/_____/_____ Date _____/_____/_____

MALE REVIEW OF SYSTEMS

Check all that apply.

- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Ear Infection
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Sinus Infection
- ☐ Sore Throat

- ☐ Chronic Cough
- ☐ Dyspnea
  (difficulty breathing)
- ☐ Snoring
  Using CPAP? (Y / N)
- ☐ Known TB Exposure
- ☐ Wheezing

- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Varicose Veins

- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting

- ☐ Sexual Dysfunction
- ☐ Penile Discharge

- ☐ Cold Intolerance
- ☐ Excessive Thirst
- ☐ Fatigue
- ☐ Gynecomastia
  (abnormal breast enlargement)
- ☐ Heat Intolerance
- ☐ Hot Flashes

- ☐ Difficulty Walking
- ☐ Headache
- ☐ Memory Loss
- ☐ Seizures
- ☐ Tremors

- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

- ☐ Contact Allergy
- ☐ Hives
- ☐ Itching Skin
- ☐ Rash

- ☐ Arthritis
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Neck Pain

- ☐ Easy Bleeding
- ☐ Lymphadenopathy
  (lymph node enlargement)
- ☐ Petechiae
  (tiny blood spots under skin)

- ☐ Asthma
- ☐ Food Allergies (please list with reactions)

_____

_____

_____

_____

_____

_____

- ☐ NO SYMPTOMS

Name _____ DOB _____/_____/_____ Date _____/_____/_____

UROLOGY REVIEW OF SYSTEMS

Please check all that apply to you today, or regarding this visit.

☐ **NO SYMPTOMS**

☐ **Chills**

☐ **Fever**

☐ **Weight Gain** (if so, amount: _____ lbs & time frame: _____)

☐ **Weight Loss** (if so, amount: _____ lbs & time frame: _____)

- Was weight loss intentional? Yes / No

☐ **Back Pain** (**Right Side** / **Left Side** / **Both**)

- Is this related to back problems? Yes / No

☐ **Change in Urine Color** => **Bloody** / **Orange** / **Dark Yellow** / **Dark Brown** / **Cloudy**

☐ **Decreased** (weak) **Stream**

☐ **Dysuria** (painful urination)

☐ **Flank** (side between ribs and hip) **Pain** => **Right** / **Left**

☐ **Foul Urine Odor**

Frequency of Urination

- How many voids during the waking hours? _____
- How often do you void during the waking hours? (please circle one below)
  Every 1-2 hours / 2-3 Hours / 3-4 Hours / Other: _____

☐ **Hesitancy** (difficulty starting urine stream)

☐ **Nocturia** (awakened from sleep by urge to void)

- How many times per night? _____

☐ **Suprapubic** (just above pubic bone in bladder area) **Pain**

☐ **Urgency** (strong sudden urge to void)

☐ **Urinary Incontinence** (leakage)

- ☐ Urge Related – associated with a strong sudden urge before leakage
- ☐ Stress Related – associated with cough, sneeze, standing, jumping, etc.
- ☐ Post-Void Dribbling (dribbling shortly after urination)
- ☐ Leakage Without Awareness of Need to Void or Without Coughing, Sneezing, etc.

How many leakage episodes per 24 hour period? _____
How do you rate your leakage? (please circle one) Mild / Moderate / Severe / Incapacitating
If you wear protective undergarments, how many do you wear per 24 hour period?
Panty Liners: _____ Pads: _____ Depends: _____

☐ **Other**: _____

Name _____ DOB _____/_____/_____ Date _____/_____/_____