NEW PATIENT ADULT

Identification Data: (Please print the following information)

Patient Name: _____ M ____ F _____ Date _____
Date of Birth: _____ Age _____ Marital Status: ___M ___Sep ___D ___W ___Single_____
Referring Physician _____Primary Care Physician _____
Chief Complaint: (Why are you seeing the doctor today?)
_____

History of Present Illness: (Please answer by circling the appropriate response)

1. Do you leak urine when you cough, strain, lift, run, or jump?	Y	N	
2. Do you leak urine when you are unable to get to the restroom on time?	Y	N	
3. Do you leak urine without feeling it?	Y	N	
4. Which is worse: leakage relating to #1 or #2:	1	2	Equal
5. How many pads to do you use in an average day for leakage?	_____Pads/day		
6. Does your urine leakage keep you from going out in public?	Y	N	
7. How many times do you leak urine in an average day?	_____/day		
8. How many times do you urinate during the day?	_____/day		
9. How many times do you urinate during the night?	_____/night		
10. Do you experience "Bedwetting"?	Y	N	
11. Do you have burning when you urinate?	Y	N	
12. Do you have to run to the restroom?	Y	N	
13. Does your bladder hurt when it gets full?	Y	N	
14. Does your bladder feel empty when you finish urinating?	Y	N	
15. Do you have trouble starting to urinate?	Y	N	
16. Do you have to push or strain to urinate?	Y	N	
17. Is your stream weak?	Y	N	
18. Does your stream start and stop?	Y	N	
19. Do you have pain your _____back,_____abdomen, or _____pelvis?			
20. Are you sexually active?	Y	N	
If YES, do you have pain with intercourse?	Y	N	
Do you leak urine during sexual intercourse?	Y	N	
21. Do you lack the desire for sex?	Y	N	

22. Have you ever had any of the following? (Please circle the appropriate response)

Bladder Infections	Kidney Infections	Kidney Stones
Blood in Urine	Constipation	Leakage of Stool

MALE PATIENTS ONLY

23. Do you have trouble *getting* an erection?	Y	N
24. Do you have trouble *maintaining* an erection?	Y	N
25. Do you have any *drainage* from penis?	Y	N
26. Do you pain/swelling in your penis/testes?	Y	N
27. If you have had a "PSA" test, what was the last value?	_____	

28. AUA Symptom Score_____ Bothersome Score_____

NAME_____ DATE OF BIRTH_____

Past Medical History: (Please list **ALL** medical conditions you have)
Please circle any of the following: (high blood pressure, high cholesterol, stroke, diabetes, heart attack, heart Murmur, gastric reflux, asthma, thyroid problems, glaucoma, breast cancer, uterine cancer, ovarian cancer)
OTHERS: _____
_____

Past Surgical History: (Please list any surgeries you had)
Please circle any of the following: (hysterectomy, cholecystectomy, appendectomy, tonsillectomy, cataracts, hip or knee replacement, inguinal hernia)
Others:_____
_____

Allergies: (Please list **ALL** medication allergies and the reaction that you had)
_____
_____

Medications: (Please list **ALL** your medications with dosage and instructions, including vitamins and supplements)

_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY: (Have any of your blood relatives had any of the following? Please circle)

Diabetes	Heart Disease	Bleeding Disorder	Kidney Failure
Strokes	Kidney Stones	High Blood Pressure	Asthma

Cancer (TYPE):_____
List immediate family members who have died (father, mother, etc...)
_____

Social History: (Do you do any of the following)

Smoke or Chew Tobacco	Y	N
(If YES, how long have you smoked_____How much?_____Packs/day)		
Drink alcohol	Y	N
Use illegal drugs	Y	N
Any exposure to chemicals/radiation	Y	N

Occupation:_____
Do you feel safe in your environment? Y N

FEMALE PATIENTS ONLY
Obstetric History: Total # of pregnancies_____ Total # of deliveries_____
Vaginal_____ C-Section_____ Weight of Largest Baby_____pounds_____ounces

NAME:_____ DATE OF BIRTH:_____

Review of Symptoms:

Have you had any problems related to the following symptoms in the last 3 months: Circle YES(Y) or NO (N). Please explain any responses of "YES" in the space provided.

General/Constitutional

- Fever Y N
- Chills Y N
- Weight Gain Y N
- Weight Loss Y N
- Other:_____

Eyes

- Blurred Vision Y N
- Double Vision Y N
- Eye Pain Y N
- Other_____

Ears/Nose/Throat

- Ear Infections Y N
- Sinus Problems Y N
- Sore Throat Y N
- Other:_____

Respiratory

- Shortness of Breath Y N
- Frequent Cough Y N
- Other:_____

Cardiovascular

- Chest Pain Y N
- Abnormal Heart Beat Y N
- Other:_____

Gastrointestinal

- Abdominal Pain Y N
- Nausea/Vomiting Y N
- Blood in Stool Y N
- Other:_____

Musculoskeletal

- Back Pain Y N
- Arthritis Y N
- Gout Y N
- Other:_____

Hematologic/Lymphatic

- Swollen Glands Y N
- Anemia Y N
- Bleeding Disorder Y N
- Other_____

Allergic/Immunologic

- Immune Disorder Y N
- Hay Fever Y N
- Other:_____

Endocrine

- Too Hot/Cold Y N
- Excessive Thirst Y N
- Tired/Sluggish Y N
- Other:_____

Neurological

- Tremors Y N
- Dizzy Spells Y N
- Migraines Y N
- Other:_____

Psychiatric

- Depression Y N
- Other:_____

Physician Signature_____