ADULT AND PEDIATRIC UROLOGY

Patient Name: _____ DOB: _____ Social Security #: _____

Date of Visit: ___/___/___ **Primary Care Physician**: _____ **Referring Provider:** _____

PATIENT EVALUATION FORM

Chief Complaint: Briefly describe what conditions bring you to see the urologist	**History of Present Illness:** When did you first notice this condition?

Oncologic History (Please check yes or no if you have ever been diagnosed with any of the following)

	Yes	No		Yes	No		Yes	No
Bladder Cancer			Breast Cancer			Penile Cancer		
Cervical Cancer			Kidney Cancer			Uterine Cancer		
Prostate Cancer			Testicular Cancer			Other Cancer		

Additional comments and Explanations:

_____

Medical History (Please check yes or no if you have ever been diagnosed with any of the following)

	Yes	No		Yes	No		Yes	No
Adopted			Allergies			Anemia		
Anesthetic Complications			Anxiety			Arthritis		
Asthma			Blood Dyscrasia			Breast Problems		
Heart Failure			Clotting Disorder			COPD (Lung Disease)		
Depression			Diabetes			Emphysema		
Heartburn			Stomach/Colon Problems			Glaucoma		
Heart Murmur			Heart Problems			HIV/AIDS		
Hyperlipidemia			Hypertension (High Blood Pressure)			Infertility		
Liver Disease			Mental Disorder			Myocardial Infarction (MI) – Heart Attack		
Osteoporosis (Bone Thinning)			Seizures			Sickle Cell Anemia		
Sleep Apnea			Spina Bifida			Stroke		
Substance Abuse			Thyroid Disease			Ulcers		

Additional comments and Explanations:

_____

Surgical History (Please check yes or no if you have ever been diagnosed with any of the following)

	Yes	No		Yes	No		Yes	No
Adenoidectomy			Appendectomy			Brain Surgery		
Breast Surgery			Heart By-Pass			Cholecystectomy (Gall Bladder Removal)		
Colon Surgery			C-Section			Eye Surgery		
Hernia Repair			Hysterectomy			Kidney Surgery		
Musculoskeletal Surgery			Prostate Surgery			Small Intestine Surgery		
Spine Surgery			Tonsillectomy			Urological Surgery		
Vasectomy			Heart Stents					

Additional comments and Explanations:

_____

Family History (Please mark relative and if they have a history of)

	Allergies	Alcohol / Drug	Asthma	Bone / Joint	Cancer	Diabetes	GI	GU / Renal	Heart / Vascular	Hyper-tension	Lipids	Neurology	Psychiatry	Pulmonary	Stroke	Thyroid	Other
Mother																	
Father																	
Sister(s)																	
Brother(s)																	
Maternal Aunt																	
Maternal Uncle																	
Paternal Aunt																	
Paternal Uncle																	
Maternal Grandma																	
Maternal Grandpa																	
Paternal Grandma																	
Paternal Grandpa																	

Additional comments and Explanations:

_____

_____

Social History (Please check the appropriate responses)

Do you Smoke? □Yes □No Past Smoking History _____ Quit Date _____ Amount Smoked _____ Years Smoked _____
Caffeine Consumption? □Yes □No Sexually Active? □Yes □No
Drinks Per Week _____ Glasses of Wine _____ Cans of Beer _____Shots of Liquor _____ Drinks Containing 0.5oz of Alcohol
Birth Control/Protection: □Abstinence □ Condom □ Diaphragm □ Implant □ Injection □ Inserts
□ IUD □ Pill □ Patch □ Rhythm □ Spermicide □ Sponge
□ Surgical □ Ring □ None
Drug Use? □Yes □No Use Per Week _____
Type: □ Marijuana □ Methamphetamines □ Cocaine □ IV □ Other

Additional comments and Explanations:

_____

_____

Allergic to: Drugs, medication, other?		
❒ No	❒ Yes – List Drug(s)	
Drug Name(s)	**Dose/Frequency**	**Reaction**

Current Medications (**Bring Bottles**)		
Drug Name(s)	**Dose/Frequency**	**Reason for Medication**

REVIEW OF SYSTEMS

In the past 60 days have you seen a physician for or have you had any problems with any of the following systems? *(Circle Y or N)*

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other: _____

Eyes/Ear/Nose/Throat/Mouth

Blurred Vision	Y	N
Double Vision	Y	N
Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Other: _____

Allergic/Immunologic

Hay Fever	Y	N

Other: _____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N

Other: _____

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N

Other: _____

Psychologic

Are you generally satisfied with your life?	Y	N
Are you being treated for depression?	Y	N

Other: _____

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N

Other: _____

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N

Other: _____

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Other: _____

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Constipation/Diarrhea	Y	N

Other: _____

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N

Other: _____

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problem	Y	N

Other: _____

THE URINARY SYMPTOM INDEX

CIRCLE YOUR RESPONSE BELOW:

		Never	Almost Never	Less than ½ the time	About ½ the time	Almost Always	Always
1.	After you urinate, do you feel like your bladder is empty?	5	4	3	2	1	0
2.	Do you need to urinate every two (2) hours?	0	1	2	3	4	5
3.	Does your urine stream start and stop while you are going?	0	1	2	3	4	5
4.	Do you get strong urges to urinate?	0	1	2	3	4	5
5.	Is your urine stream weak?	0	1	2	3	4	5
6.	Do you need to push or strain to start urinating?	0	1	2	3	4	5
7.	Do you need to get up at night to urinate?	0	1	2	3	4	5

Symptom Score = Sum of Questions 1 to 7 Insert Your Total Here _____