

Northern Virginia Urology, PLLC

Please Print

Name: (Last, First, Middle) _____ Date of Birth: ___/___/___ Account # _____

Illnesses – Please list all major illnesses

Surgeries - Please list any surgical procedures

Procedure	Year	Procedure	Year

Medications – Please list **ALL CURRENT** medicines

Medication	How Much/How Often	Medication	How Much/How Often

Aspirin **Y** **N**

Allergies – Please list all **MEDICATION** allergies

Social History

Smoking	Y N	I smoke(d) _____ packs/day for _____ years	OR I quit _____ years ago.
Alcohol	Y N	I have _____ drinks/day OR I drink socially (less than 3 drinks/week)	

Family Medical History

	# Answers	Level of Service
Father:	1 - 3	1 or 2
Mother:	4 +	3 - 5
Other:		

↓ **Physician use Only** ↓

Review of Systems: Do you **CURRENTLY** have any problems related to the following systems? Circle Y (es) or N (o).

<p>General</p> <p>Fever Y N</p> <p>Chills Y N</p> <p>Headache Y N</p> <p>Other Y N</p> <p>Eyes</p> <p>Blurred Vision Y N</p> <p>Double Vision Y N</p> <p>Pain Y N</p> <p>Other Y N</p> <p>Ear/Nose/Throat</p> <p>Ear Infection Y N</p> <p>Sore Throat Y N</p> <p>Sinus Problem Y N</p> <p>Other Y N</p> <p>Hematologic/Lymphatic</p> <p>Swollen Gland Y N</p> <p>Bleeding Problem Y N</p> <p>Other Y N</p>	<p>Respiratory</p> <p>Wheezing Y N</p> <p>Cough Y N</p> <p>Short of Breath Y N</p> <p>Other Y N</p> <p>Musculoskeletal</p> <p>Joint Pain Y N</p> <p>Neck Pain Y N</p> <p>Back Pain Y N</p> <p>Other Y N</p> <p>Cardiovascular</p> <p>Chest Pain Y N</p> <p>Palpitations Y N</p> <p>Hypertension Y N</p> <p>Other Y N</p> <p>Allergy/Immunology</p> <p>Hay Fever Y N</p> <p>Drug Allergy Y N</p> <p>Other Y N</p>	<p>Gastrointestinal</p> <p>Stomach Pain Y N</p> <p>Nausea Y N</p> <p>Vomiting Y N</p> <p>Indigestion Y N</p> <p>Other Y N</p> <p>Endocrine</p> <p>Too Thirsty Y N</p> <p>Too Hot/Cold Y N</p> <p>Tiredness Y N</p> <p>Other Y N</p> <p>Skin</p> <p>Skin Rash Y N</p> <p>Persistent Itch Y N</p> <p>Other Y N</p> <p>Psychological</p> <p>Depression Y N</p> <p>Other Y N</p>	<p>Urological</p> <p>Urinate Often Y N</p> <p>Painful Urination Y N</p> <p>Urinate Slowly Y N</p> <p>Urinate at Night Y N</p> <p>Urinary Leakage Y N</p> <p>Incomplete Emptying Y N</p> <p>Other Y N</p> <p>Neurological</p> <p>Tremors Y N</p> <p>Dizzy Spells Y N</p> <p>Numbness Y N</p> <p>Tingling Y N</p> <p>Other Y N</p>
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Physician use only: (Notes/Comments)	# Answers	Level of Service
	1 - 3	1 or 2
	4 +	3 - 5

Physician Signature _____ Date _____