

UROLOGY

HISTORY & PHYSICAL

Date: _____

Name: _____ Marital Status S M W D SEP Date of Birth _____

Address: _____ Phone (h) _____

Occupation/Employer _____ Phone(w) _____

Who is your primary care physician? _____ Referred by _____

For what reason are you seeing the doctor? _____

Do you have any drug allergies? _____

Please list ALL medications (dosage/freq)

Please list all hospitalizations or surgeries

1. _____	6. _____	<u>YEAR</u>	<u>REASON</u>	<u>YEAR</u>	<u>REASON</u>
2. _____	7. _____	_____	_____	_____	_____
3. _____	8. _____	_____	_____	_____	_____
4. _____	9. _____	_____	_____	_____	_____
5. _____	10. _____	_____	_____	_____	_____

FAMILY HISTORY

Does anyone in your family have:	RELATIVE		RELATIVE
1. Bleeding tendencies	Y N _____	5. Prostate cancer	Y N _____
2. Diabetes	Y N _____	6. Cancer	Y N _____
3. Kidney disease	Y N _____	7. Kidney stones	Y N _____
4. Gout	Y N _____	8. Heart trouble	Y N _____

REVIEW OF SYMPTOMS

Do you have now or have you ever had any of the following?

Respiratory

Bronchitis _____
Emphysema _____
Asthma _____
Shortness of breath _____

Gastrointestinal

Hiatal hernia _____
Ulcers _____
Colitis _____
Abdominal pain _____
Blood in stool _____

Constitutional Systems

Fever _____
Chills _____
Weight loss _____
Appetite change _____
Headaches _____
Cancer _____
Depression _____

Urological

Kidney stones _____
Slow stream _____
Bedwetting _____
Inability to pass urine _____

Are you having pain? Y N
Where? _____
Urinary tract infection _____
Blood in urine _____
Trouble emptying bladder _____

Cardiovascular

Arrhythmia, irregular pulse _____
Heart murmur, valve disease _____
High blood pressure _____
Heart attack _____
Angina _____
Phlebitis _____
Circulatory problems _____
Rheumatic fever _____

Endocrine

Thyroid disease _____
Diabetes _____
Pituitary disease _____

Musculoskeletal

Osteoporosis _____
Joint pain _____
Fractures _____
Gout _____

Skin

Shingles _____

Rashes/Hives _____

Neurological

Seizures _____
Stroke _____
Parkinson's disease _____

Nephrological

Renal disease _____
Nephritis _____

Hematological

Hepatitis/Jaundice _____
Bleeding tendency _____
Swollen glands _____
HIV(AIDS) _____

Have you seen a Psychiatrist? Y N

Marital counselor? Y N

Do you smoke cigarettes? Y N

Quantity per day: _____

Do you drink alcohol? Y N

Quantity per week: _____

FEMALES:

Pregnancies: _____

Last menstrual period _____