

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

## Reason For Current Visit

### Women

- Frequent urination/incontinence  
*(Ask for handout #1)*
- Pelvic/bladder pain, interstitial cystitis
- Blood in urine
- Kidney stone
- Other \_\_\_\_\_

Are you now pregnant? \_\_\_\_\_

### Men

- Frequent urination/incontinence  
*(Ask for handout #1)*
- Erectile dysfunction *(Ask for handout #3)*
- Prostatitis/pelvic pain
- Elevated PSA
- Testicular pain/infection
- Blood in urine
- Other \_\_\_\_\_

**Are you ALLERGIC OR SENSITIVE to any medications or radiographic dye? (List medication and reaction)**

- I have no allergies \_\_\_\_\_

**List all your CURRENT MEDICATIONS and dosages, including supplements? (Example: Lipitor 10 mg daily, Saw Palmetto Herbs.)**

- I take no medications \_\_\_\_\_

## Past Medical & Surgical History

**List all your illnesses.**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Irregular Rhythm   | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Gastritis/Ulcer  | <input type="checkbox"/> Kidney Cancer      | <input type="checkbox"/> Thyroid Disease  |
| <input type="checkbox"/> Bladder Cancer             | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Kidney Stones      | <input type="checkbox"/> Urine Infections |
| <input type="checkbox"/> Cancer (list)              | <input type="checkbox"/> Heart Attack     | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Vascular Disease |
| _____   | <input type="checkbox"/> Heart Murmur     | <input type="checkbox"/> Parkinson=s        | <input type="checkbox"/> Venereal Disease |
| _____   | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Phlebitis          |   |
| <input type="checkbox"/> Cirrhosis                  | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Cancer    |   |
| <input type="checkbox"/> Depression                 |   |   |   |
| <input type="checkbox"/> I have no medical problems | _____                                     | _____                                       | _____                                     |

**List all your operations, including dates (Example: Hernia repair 1991, etc)**

- I have had no surgery \_\_\_\_\_

(Please complete other side) ^

# Family History

List all medical illnesses in your immediate family. Include grandparents, parents, and siblings but not your spouse. (Example: Diabetes, colon cancer, etc)

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

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# Review of Systems

Do you now or have you recently had any of the following problems? (Please circle Y or No for EVERY problem)

### Constitutional symptoms

Fever	Y	N
Headache	Y	N
Weight loss/gain	Y	N
Other _____		

### Eyes

Glaucoma	Y	N
Double vision	Y	N
Other _____		

### Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness	Y	N
Other _____		

### Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Other _____		

### Gastrointestinal

Abdominal pain	Y	N
Nausea/Vomiting	Y	N
Heartburn	Y	N
Constipation	Y	N
Diarrhea	Y	N
Other _____		

### Cardiovascular

Chest pain	Y	N
Swelling of feet	Y	N
Circulatory prob	Y	N
Other _____		

### Skin

Rash	Y	N
Other _____		

### Musculoskeletal

Joint pain	Y	N
Back pain	Y	N
Weakness	Y	N

### ENT

Ear infections	Y	N
Sinus problems	Y	N
Hay fever	Y	N
Other _____		

### Respiratory

Wheezing/Asthma	Y	N
COPD/Emphysema	Y	N
Shortness of breath	Y	N
Other _____		

### Hematology

Bleeding problem	Y	N
Anemia	Y	N
Other _____		

### Psychologic

Depression	Y	N
Anxiety	Y	N

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# Social History

Do you smoke?	Y	N	If yes, how many packs/day? _____	Quit _____ years ago?
Do you drink alcohol?	Y	N	If yes, how many glasses per week? _____	
Do you use drugs?	Y	N	If yes, which ones? _____	