



Reason For Current Visit

Name: _____ Age: _____ Today's Date: _____

Referring Doctor: _____

WOMEN

MEN

- Frequent urination/incontinence**
(ask for Handout 1)
- Pelvic/Bladder pain, Interstitial Cystitis**
(ask for Handout 1)
- Sexual Dysfunction (dryness, pain, etc)**
- Other:** _____

- Frequent urination/incontinence**
(ask for Handout 2)
- Erectile Dysfunction**
(ask for Handout 3)
- Prostatitis/Pelvic pain**
(ask for Handout 4)
- Elevated PSA**
- Testicular Pain/Infection**
- Other:** _____

Are you pregnant? Yes No
 Date of last menstrual period? _____
 Date of last PAP smear? _____
 Date of last mammogram? _____

Are you Allergic or Sensitive to any medications or radiographic dyes? NO YES (list below)

Are you taking any Medications? NO YES (Please write the medication name and dosage)

Medical History I have no medical problems/illnesses

Please check off all your illnesses, and write down any that are not listed below.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer (List) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Disease |
| _____ | <input type="checkbox"/> Gastritis/Ulcer | <input type="checkbox"/> Irregular Rhythm | <input type="checkbox"/> Urine Infections |
| _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Vascular Disease |
| _____ | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Multiple Schlerosis | <input type="checkbox"/> Venereal Disease |

Other: _____

Surgical History Have you ever had surgery? NO YES (Please list surgery below and date)

Family History – Please list all serious illnesses in your immediate family (this includes grandparents, parents, siblings, children, but not your spouse).

Review of Systems – Are you currently experiencing any of the conditions listed below?

Constitutional Systems

Fever Y N
 Chills Y N
 Headache Y N
 Weight loss/gain Y N

Gastrointestinal

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

ENT

Ear infections Y N
 Sore throat Y N
 Sinus Problems Y N
 Hay Fever Y N

Eyes

Blurred Vision Y N
 Double Vision Y N

Cardiovascular

Chest pain Y N
 Swelling feet Y N
 Circulatory problems Y N

Respiratory

Wheezing Y N
 Frequent cough Y N
 Shortness of breath Y N

Neurological

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

Skin

Rash Y N
 Boils Y N
 Itching Y N

Hematology

Swollen glands Y N
 Bleeding problems Y N
 Anemia Y N

Endocrine

Excessive thirst Y N
 Too hot/cold Y N
 Tired/sluggish Y N

Musuloskeletal

Joint pain Y N
 Back pain Y N
 Weakness Y N

Psychologic

Depression Y N
 Anxiety Y N
 Hyperactivity Y N
 Alcoholism Y N

Other (please describe) :

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/week? _____
 Do you use recreational drugs? Y N If yes, which ones? _____