

Patient Name: \_\_\_\_\_ Chart # / Office: \_\_\_\_\_

Home / Cell Phone: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Pharmacy Name & Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS:**

What is your reason for your visit today? \_\_\_\_\_

**ALLERGIES**

Are you Allergic to any medication?  No  Yes (If yes please list & describe the reaction below.)

MEDICATION ALLERGY	REACTION

Are you allergic to: Latex  No  Yes Iodine  No  Yes Dye or contrast material  No  Yes Other \_\_\_\_\_

**MEDICATION**

ARE YOU CURRENTLY TAKING ANY MEDICATIONS?  NO  YES (If yes please list all current medications prescribed by other physicians including over the counter supplements and herbal medications.) **Please list below ↓↓**

MEDICATIONS	DOSE (example one 20mg tablet once daily)	DISCONTINUE DATE	PRESCRIBING DOCTOR

Do you take Aspirin?  No  Yes Do you take a Blood Thinner?  No  Yes If yes what Blood Thinner? \_\_\_\_\_  
*Do you require medications or antibiotics before procedures?*  Yes  No

**SURGICAL HISTORY**

**SURGICAL HISTORY - Please list & note dates of your surgeries:** \_\_\_\_\_

\_\_\_\_\_

**UROLOGIC SURGERY - Please list & note dates of your urology surgeries:** \_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY**

**MEDICAL PROBLEM - Please list your Major Medical Problems & Dates of Hospitalizations:** \_\_\_\_\_

\_\_\_\_\_

**UROLOGIC MEDICAL PROBLEM - Please list your Major Medical Problems & Dates of Hospitalizations:** \_\_\_\_\_

\_\_\_\_\_

**FAMILY medical history;** have any family members had:

**Cancer**  No  Yes, **if yes where?**  Prostate  Kidney  Bladder  Breast  Other: \_\_\_\_\_  
 Family member:  Mother  Father  Grandmother  Grandfather  Brother  Sister  Aunt  Uncle  
 Runs in the Family  No Family History

**Heart Problems**  No  Yes, **if yes who?**  
 Family member:  Mother  Father  Grandmother  Grandfather  Brother  Sister  Aunt  Uncle  
 Runs in the Family  No Family History

**Kidney Disease**  No  Yes, **if yes who?**  
 Family member:  Mother  Father  Grandmother  Grandfather  Brother  Sister  Aunt  Uncle  
 Runs in the Family  No Family History

**Diabetes**  No  Yes, **if yes who?**  
 Family member:  Mother  Father  Grandmother  Grandfather  Brother  Sister  Aunt  Uncle  
 Runs in the Family  No Family History

**PLEASE COMPLETE REVERSE SIDE ⇨**

**SOCIAL HISTORY**

**Marital Status**  Married  Single  Divorced  Widowed  Separated  Unknown  
**Smoking Status**  **Current** Every Day **Smoker**  Current Some Day (Occasional) Smoker  Packs smoked per day \_\_\_\_\_  
 When did you start smoking? \_\_\_\_\_ Approximately \_\_\_\_  Days  Weeks  Months  Years Ago  
 **Former Smoker**  
 When did you quit smoking? \_\_\_\_\_ Approximately \_\_\_\_  Days  Weeks  Months  Years Ago  
 Packs smoked per day \_\_\_\_\_ How long did you smoke \_\_\_\_  Days  Weeks  Months  Years  
 **Never smoked**  Smoker current status unknown  Unknown if ever smoked

**Do You Drink Alcohol?**  **Never Drank**  
 **Yes**, Drinks per Day \_\_\_\_ Week \_\_\_\_ Month \_\_\_\_ Year \_\_\_\_ Type of alcohol consumed  Beer  Wine  Liquor  
 Drinking Habits:  Social  Light  Moderate  Excessive  
 **Not Anymore** When did you quit? \_\_\_\_\_ Approximately \_\_\_\_  Days  Weeks  Months  Years ago  
 How long did you drink? \_\_\_\_\_  Days  Weeks  Months  Years  
 How much did you drink? \_\_\_\_\_ Drink/s per  Day  Week  Month  Year

**How many caffeinated drinks do you have each day?**  0  1  2  3  4+

**Have you had a blood transfusion?**  Yes  No  
**What language do you speak?**  English  Spanish  French  German  Portuguese  Russian  Chinese  
 Japanese  Italian  Arabic  Other \_\_\_\_\_  
**What race are you?**  White  Black African American  American Indian / Alaska Native  Eskimo  
 Native Hawaiian / Pacific Islander  Hispanic  Asian  Unknown \_\_\_\_\_  
**What ethnicity are you?**  Hispanic or Latino  Not Hispanic or Latino

**GENERAL REVIEW OF SYSTEMS:** Are you currently having any of the following?

<b>Genitourinary</b>		Depression	<input type="checkbox"/> Y <input type="checkbox"/> N	Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N
Incontinence	<input type="checkbox"/> Y <input type="checkbox"/> N	Bi-Polar disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N
Voiding difficulties	<input type="checkbox"/> Y <input type="checkbox"/> N	Manic depressive	<input type="checkbox"/> Y <input type="checkbox"/> N	Other _____	
Painful urination	<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Musculoskeletal</b>	
Urine retention	<input type="checkbox"/> Y <input type="checkbox"/> N	Other _____		CVA Tenderness	<input type="checkbox"/> Y <input type="checkbox"/> N
Urinary frequency	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Endocrine</b>		Back Pain	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood in Urine	<input type="checkbox"/> Y <input type="checkbox"/> N	Hot Flashes	<input type="checkbox"/> Y <input type="checkbox"/> N	Neck Pain	<input type="checkbox"/> Y <input type="checkbox"/> N
Stones	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Thirst	<input type="checkbox"/> Y <input type="checkbox"/> N	Joint Pain	<input type="checkbox"/> Y <input type="checkbox"/> N
Currently sexually active	<input type="checkbox"/> Y <input type="checkbox"/> N	Too Hot / Too Cold	<input type="checkbox"/> Y <input type="checkbox"/> N	Other _____	
Sexually Transmitted Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Hematologic / Lymphatic</b>	
Other _____		Other _____		Bleeding Tendencies	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Male</b>		<b>Gastrointestinal</b>		Swollen Glands	<input type="checkbox"/> Y <input type="checkbox"/> N
Trouble with erections	<input type="checkbox"/> Y <input type="checkbox"/> N	Constipation	<input type="checkbox"/> Y <input type="checkbox"/> N	Lymphoma / Leukemia	<input type="checkbox"/> Y <input type="checkbox"/> N
Trouble with Ejaculation	<input type="checkbox"/> Y <input type="checkbox"/> N	Nausea / Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N	Other _____	
Libido Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Hernia	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Integumentary</b>	
Low Testosterone	<input type="checkbox"/> Y <input type="checkbox"/> N	Abdominal Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin Rash	<input type="checkbox"/> Y <input type="checkbox"/> N
Infertility	<input type="checkbox"/> Y <input type="checkbox"/> N	Other _____		Boils	<input type="checkbox"/> Y <input type="checkbox"/> N
Other _____		<b>Respiratory</b>		Skin Infection	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Female</b>		Shortness of Breath	<input type="checkbox"/> Y <input type="checkbox"/> N	Other _____	
Do you still have a menstrual period	<input type="checkbox"/> Y <input type="checkbox"/> N	Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Ears, Nose &amp; Throat</b>	
Number of pregnancies _____		Frequent Cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Hearing Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Number of Vaginal Births _____		Pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> N	Sore Throat	<input type="checkbox"/> Y <input type="checkbox"/> N
Most recent pelvic / pap exam _____		Other _____		Swallowing Issues	<input type="checkbox"/> Y <input type="checkbox"/> N
Other _____		<b>Constitutional Symptoms</b>		Other _____	
<b>Cardiovascular</b>		Fever / Chills	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Allergy / Immunological</b>	
Chest Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Weight Loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Seasonal Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N
High blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N	Other _____	
Elevated Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	Anorexia	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Eyes</b>	
Irregular Heartbeat	<input type="checkbox"/> Y <input type="checkbox"/> N	Other _____		Blurred Vision	<input type="checkbox"/> Y <input type="checkbox"/> N
Other _____		<b>Neurological</b>		Double Vision	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Psychologic</b> next column →		Headache	<input type="checkbox"/> Y <input type="checkbox"/> N	Other _____	
		Tremors	<input type="checkbox"/> Y <input type="checkbox"/> N		

PATIENT SIGNATURE: \_\_\_\_\_ DOCTOR SIGNATURE: \_\_\_\_\_

**MEDICATION REVIEW - FOR OFFICE USE ONLY**

DATE REVIEWED	MA INITIALS	DATE REVIEWED	MA INITIALS	DATE REVIEWED	MA INITIALS	DATE REVIEWED	MA INITIALS	DATE REVIEWED	MA INITIALS