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UROLOGY PATIENT FORM

Name: _____ DOB: _____/_____/_____ Age: _____

What is the reason for your visit today? _____

When did you first notice the problem? _____

Does anything help or make the problem worse? _____

Is it constant? ☐ Or come and go? ☐ Severity on a scale from 1 – 10 (10 being most severe) _____

PREFERRED PHARMACY: _____

SOCIAL HISTORY

Do you smoke? □ No □ Yes _____x per day □ Former _____years

Do you use smokeless tobacco? □ No □ Yes _____x per day □ Former _____years

Marijuana? ☐ No ☐ Yes ☐ Former Methamphetamine? ☐ No ☐ Yes ☐ Former

Caffeine: ☐ No ☐ Yes _____x a day Alcohol: ☐ No ☐ Yes ☐ Former _____oz per day

ALLERGIES: Do you have any other allergies?

Medication	Food	Environmental

Are you allergic to latex? □ No □ Yes **Are you allergic to Betadine/Iodine?** □ No □ Yes

REVIEW OF SYSTEMS: please check any of the following symptoms

Constitutional
□ Appetite change
□ Chills
□ Fatigue
□ Fever
□ Weight gain/loss

ENT
□ Hearing loss
□ Sore throat
□ Trouble swallowing

Eyes
□ Eye pain
□ Visual disturbance

Respiratory
□ Choking
□ Cough
□ Shortness of breath
□ Wheezing

Cardiovascular
□ Chest pain
□ Leg swelling

GI
□ Abdominal pain
□ Constipation
□ Diarrhea
□ Nausea
□ Vomiting

Endocrine
□ Cold intolerance
□ Heat intolerance

GU
□ Difficulty urinating
□ Dysuria (painful urination)
□ Hematuria (blood in urine)
□ Penile pain
□ Testicular pain
□ Urinary urgency

Musculoskeletal
□ Back pain
□ Myalgia's (Muscle Aches)

Skin
□ Rash

Allergy
□ Food allergy

Neurological
□ Dizziness
□ Numbness
□ Weakness

Hematology
□ Bruises easily

Psychiatric
□ Confusion
□ Sleep disturbance

Medication Name:	Dosage:	Frequency:	Reason:

Family History:

Family Member	Age	Illness
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Infections:

□ Hepatitis **A** **B** **C** (please circle) □ HIV □MRSA □ Scabies □Tuberculosis □ Body Lice □ C. Diff

□ Other: _____

Surgical History:

Date:	Type:	Hospital:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever change in health condition.

_____ _____

Signature of patient or personal representative Date