Patient's Name	Date
Who referred you to this office?	Medical Doctor/PCP
Why are you seeing the physician today?	
When did your problem start?	Pharmacy (Name & Number)

My Main Problems are:

☐ Enlarged Prostate ☐ Blood in Urine ☐ High PSA ☐ Bladder Infection
☐ Kidney Stones ☐ Prostate Infection ☐ Urinary Incontinence ☐ Bladder Cancer
☐ Prostate Cancer ☐ Erectile Dysfunction ☐ Overactive Bladder ☐ Infertility
☐ Lump in Testicle ☐ Other: ______________________________

Allergies:

☐ None ☐ PCN ☐ Sulfa ☐ Cipro ☐ Iodine/Contrast
☐ Other: ______________________________

Medications (Please list all current medications):

____

Surgical History: ☐ Appendectomy ☐ Back/Hip/Knee ☐ Cystoscopy ☐ Gallbladder
☐ Heart Bypass ☐ Kidney Stone Surgery ☐ Lithotripsy ☐ Prostate Biopsy ☐ Prostate Seed
☐ Prostate Surgery ☐ Other: ______________ ☐ **No Changes**

Medical History: ☐ Diabetes ☐ Emphysema ☐ Heart Attack ☐ Heart Murmur
☐ Hepatitis ☐ Hernia ☐ Hypertension ☐ Parkinson's ☐ Strokes
Cancer: ☐ Prostate ☐ Kidney ☐ Testis ☐ Other: __________ ☐ **No Changes**

Family History: ☐ Prostate Cancer ☐ Kidney Cancer ☐ Kidney Stones ☐ Heart Disease

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Smoke: ☐ No ☐ Yes **Occupation:** ______________ ☐ Retired

My Symptom(s) are:

General/Constitutional	☐ Fever	☐ Weight Loss	☐ Chills
Eyes	☐ Blurry Vision	☐ Double Vision	☐ Cataracts
Ears, Nose, Mouth, Throat	☐ Hearing Loss	☐ Nasal Stuffiness	☐ Sore Throat
Cardiovascular	☐ Chest Pains	☐ Swollen Ankles	☐ Irregular Heartbeat
Respiratory	☐ Shortness of Breath	☐ Wheezing	☐ Chronic Cough
Gastrointestinal	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Change in Bowels
Genitourinary	☐ Incontinence	☐ Painful Urination	☐ Blood in Urine
Musculoskeletal	☐ Chronic Back Pain	☐ Chronic Neck Pain	☐ Sore Muscles
Integumentary/Skin	☐ Rash	☐ Persistent Itching	☐ Skin Cancer History
Neurologic	☐ Numbness	☐ Tingling	☐ Dizziness
Hematologic/Lymphatic	☐ Swollen Glands	☐ Abnormal Bleeding	☐ Transfusion History

Urinary Symptom(s) are:

☐ Incomplete Emptying ☐ Frequency ☐ Intermittency ☐ Weak Stream ☐ Straining
☐ Testicle Pain ☐ Pain in Side R / L ☐ Urinating at Night # _____