SKYLINE UROLOGY

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:

☐ Blood in Urine ☐ Bladder Cancer ☐ Bladder Infection ☐ Bladder Pain
☐ Kidney Stones ☐ Interstitial Cystitis ☐ Leak Urine ☐ Overactive Bladder
☐ Dropped Bladder ☐ Other: _____

Allergies:

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

Medications: ☐ None ☐ Aspirin ☐ Lortab ☐ Percocet ☐ Plavix ☐ Nitroglycerin
☐ Detrol ☐ Detrol LA ☐ Vesicare ☐ Allopurinol ☐ Coumadin
☐ Antibiotic: _____ ☐ Other: _____

Surgical History: ☐ Appendectomy ☐ Back/Hip/Knee ☐ Bladder Tack ☐ C-Section # _____
☐ Cystoscopy ☐ Gallbladder ☐ Heart Bypass ☐ Hysterectomy ☐ Kidney Stone Surgery
☐ Lithotripsy ☐ Sling (TVT) ☐ Vaginal Deliveries # _____ ☐ Other: _____
☐ **No Changes**

Medical History: ☐ Diabetes ☐ Emphysema ☐ Heart Attack ☐ Heart Murmur
☐ Hepatitis ☐ Hernia ☐ Hypertension ☐ Last Period: _____ ☐ Menopause
☐ Parkinson's ☐ Pregnant ☐ Strokes ☐ Cancer: _____
☐ Other: _____ ☐ **No Changes**

Family History: ☐ 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:

☐ Frequency ☐ Urgency ☐ Leakage ☐ Straining ☐ Abdominal Pain
☐ Bladder Pain ☐ Pain in Side R / L ☐ Not Emptying Bladder ☐ Urinating at Night # _____