

PRINCE WILLIAM UROLOGY ASSOCIATES, LTD

Ali M Sajadi, MD - Andrew K Chung, MD - Amy K Moreno, MD - Anshu Guleria, MD- Katie Riley- PA-C

New Patient Urologic History Form - Men

Patient's Name: _____
(Last) (First) (MI) (Date)

Age: _____ DOB: _____ Height _____ Weight _____

Referring Dr: _____ Primary Dr: _____

What is the *main reason* for your visit today? Write in your own words on the lines provided:

When did you first notice the problem? _____

Location of the problem? (if applicable) _____

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem.

1 2 3 4 5 6 7 8 9 10 N/A

How long does the problem last? _____ Is the problem: Constant Variable Seldom

Does anything make the problem worse? _____ If yes, what makes it worse? _____

Does anything make the problem better? _____ If yes, what makes it better? _____

Does the problem interfere with your normal activities? Yes No

What testing have you had to evaluate your urological problem?

I have had no tests to evaluate this problem

X-ray

Ultrasound

Urodynamic Testing

CT scan

Nuclear bone scan

Other: _____

MRI

Nuclear renal scan

Unsure

IVP

Urine specimen

Blood tests

Cystoscopy

Where was the test performed? _____

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Do you leak urine? Yes No

Is your leakage associated with the urge to urinate? Yes No

Is your leakage associated with coughing, laughing, jumping, sneezing, or exercising? Yes No

Do you wear protective pads? Yes No If so, how many? _____

Do you have a problem with libido/desire? Yes No

Do you have a problem achieving or maintaining an erection? Yes No

Have you tried any medications for erectile dysfunction? Yes No

If yes, please indicate which medication(s) below:

Viagra Cialis Levitra Staxyn MUSE Injection therapy Other: _____

Would you like to discuss erectile function with your doctor today? _____ (Note: an additional appointment may be required if this is not your primary problem)

Are there any other urologic issues you would like to discuss with Dr. _____ today? Yes No

(Please explain:) _____

Allergies: Are you allergic to:

Latex

Iodine/Betadine

Penicillin

Dye/IV Contrast

Tape/Adhesives

Sulfa

Shellfish/Shrimp!

Anesthetics

Cipro/Levaquin

I have no medication allergies

Medication allergies: (List all)

Medications:

Do you take any medications? Yes No

Are you currently taking the following blood thinners? Aspirin 81 mg or 325 mg

Motrin Aleve Ibuprofen Celebrex Mobic Other: _____

Coumadin Warfarin Plavix Pradaxa Xarelto Eliquis Heparin Lovenox

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Please list all the medications you take with the dosage and frequency:

<u>Medication</u>	<u>Dose</u>	<u>How Often</u>

Please list all Vitamins & Supplements such as Vitamin E, Fish oil, Herbal preparation, Garlic, etc:

Past & Present Medical Problems

- | | | |
|---|---|---|
| <input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Carotid artery disease
<input type="checkbox"/> Congestive heart failure
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Heart attack
<input type="checkbox"/> Peripheral vascular
<input type="checkbox"/> Heart valvular disease
<input type="checkbox"/> Renal artery stenosis
<input type="checkbox"/> Heart disease
<input type="checkbox"/> Asthma
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> COPD
<input type="checkbox"/> Cystic fibrosis
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Pulmonary embolism
<input type="checkbox"/> Sarcoidosis
<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Crohn's disease
<input type="checkbox"/> Heartburn/GERD | <input type="checkbox"/> Diverticulosis
<input type="checkbox"/> Kidney failure
<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Polycystic kidney disease
<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Vesicoureteral reflux
<input type="checkbox"/> Kidney infections/UTI
<input type="checkbox"/> Kidney obstruction
<input type="checkbox"/> Enlarged prostate/BPH
<input type="checkbox"/> Prostate infection
<input type="checkbox"/> STD's
<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Gout
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Polio
<input type="checkbox"/> Artificial joints
<input type="checkbox"/> Lupus
<input type="checkbox"/> Addison's Disease
<input type="checkbox"/> Cushing's disease
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Myasthenia gravis
<input type="checkbox"/> Parkinson disease
<input type="checkbox"/> Seizures
<input type="checkbox"/> TIA
<input type="checkbox"/> Anemia
<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Blood clots
<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Drug dependency
<input type="checkbox"/> Depression
<input type="checkbox"/> Bladder cancer
<input type="checkbox"/> Breast cancer
<input type="checkbox"/> Cervical cancer
<input type="checkbox"/> Colon cancer
<input type="checkbox"/> Kidney cancer
<input type="checkbox"/> Lung cancer
<input type="checkbox"/> Penile cancer
<input type="checkbox"/> Prostate cancer
<input type="checkbox"/> Skin cancer
<input type="checkbox"/> Testicular cancer |
|---|---|---|

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- | | | |
|---|---|---|
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Uterine cancer |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer, Other: |
| <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Peptic ulcer disease | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> Dementia | _____ |

Surgical History

Date	Surgery	Date	Surgery

Family History (please indicate which family member)

- | | | |
|---|---|--|
| <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Prostate cancer |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney cancer |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bladder cancer | <input type="checkbox"/> Other: _____ |

Tobacco/ Alcohol History

- Do you currently smoke? Yes No How much? _____
- Did you smoke in the past? Yes No How long? _____ When did you quit? _____
- Do you drink alcohol? Yes No How many drinks per day? _____
- Do you use recreational drugs? Yes No Substances: _____

Thank you for taking the time to complete your urological health questionnaire. Welcome to our practice! Prince William Urology Associates, Ltd.

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REVIEW OF SYSTEMS

Name: _____

Date: _____

Please check only the problems that **currently** apply to you

CONSTITUTIONAL

- Fever
- Chills
- Weight gain
- Weight loss

EYES

- Blurred vision
- Vision loss

EARS/NOSE/THROAT

- Hearing loss
- Sinus problems
- Difficulty swallowing
- Sore throat
- Dental problems
- Nose bleeds

CARDIOVASCULAR

- Chest pain
- Palpitations
- Irregular heartbeat
- Swelling of feet/
Extremities

RESPIRATORY

- Shortness of breath
- Chronic cough
- Coughing up blood

GASTROINTESTINAL

- Poor appetite
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Abdominal pain
- Blood in stool
- Heartburn

GENITOURINARY

- Blood in urine
- Easy bruising
- Leakage of urine
- Weak stream
- Frequency urination
- Urge to void suddenly
- Getting up at night to
Urinate
- Problems with erection
- Pain with intercourse
- Bladder pain
- Pelvic pain
- Burning with urination
- Frequent urine infections

MUSCULOSKELETAL

- Back pain
- Joint pain
- Muscle aches

INTEGUMENTARY/SKIN

- Rash
- Atypical moles
- Itchy skin

NEUROLOGIC

- Numbness
- Weakness
- Dizziness

HEMATOLOGIC/LYMPHATIC

- Bleeding tendency
- Swollen lymph gland

ENDOCRINE

- Excessive thirst
- Hot/cold Intolerance
- Hormone problem
- Fatigue

ALLERGY

- Medication allergy
- Latex allergy
- Seasonal allergy

PSYCHIATRIC

- Depression
- Anxiety

****Healthcare provider only:** The above systems have been reviewed by: _____

Physician's initials