Name: ___________________________ **Date:** ________________

DOB: ___________

Welcome to our office or welcome back. We want to provide you with the best possible care, so please take a few moments to complete the following pages. Thank you.

What is the main urologic issue you would like to discuss?

____
____
____

Do you have any other urologic issues you would like addressed?

____
____
____

Please list any medical conditions you have (high blood pressure, diabetes, etc.:

1. _____________________________________ 4. _____________________________________
2. _____________________________________ 5. _____________________________________
3. _____________________________________ 6. _____________________________________

Please list any prior surgeries or procedures: **Date of surgery/procedure:**

1. _____________________________________ _____________________________________
2. _____________________________________ _____________________________________
3. _____________________________________ _____________________________________
4. _____________________________________ _____________________________________

Name: ___________________________

DOB: ___________________

Please list any current medications/herbal supplement: **Dose:**

1. ____ ___________________________________
2. ____ ___________________________________
3. ____ ___________________________________
4. ____ ___________________________________
5. ____ ___________________________________
6. ____ ___________________________________
7. ____ ___________________________________
8. ____ ___________________________________
9. ____ ___________________________________
10. ____ ___________________________________

Please list any medications you are allergic to: **Reaction:**

1. ____ ___________________________________
2. ____ ___________________________________
3. ____ ___________________________________
4. ____ ___________________________________

Please list any serious illness in your family:

Relative: _______________________________________ Illness: ____________________________

Relative: _______________________________________ Illness: ____________________________

Relative: _______________________________________ Illness: ____________________________

Name: ___________________________

DOB: ___________________

FEMALE PATIENTS ONLY:

Ashkenazi Jewish Ancestry? Yes ☐ No ☐
Have you or any one in your family been diagnosed with ovarian cancer? Yes ☐ No ☐
Have you or any one in your family been diagnosed with pancreatic cancer? Yes ☐ No ☐
Have you or any one in your family been diagnosed with breast cancer <50 years old? Yes ☐ No ☐
Have you or any one in your family been diagnosed with any other type of cancer(s)? If yes, please indicate what type: _________________________________ Yes ☐ No ☐

Number of pregnancies: _________________ Number of deliveries: ___________________

Vaginal or C-section: ____________________ Birth weights: _________________________

Age of menopause: _____________________ Hormone replacement: _________________

****

Please indicate your current marital status:

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐

On average, how many alcoholic beverages do you have in a week? ____________________________

Did you ever smoke on a regular basis? Yes ☐ No ☐

If yes, how many packs a day? _______________ For how many years? _________

Are you still smoking? Yes ☐ / No ☐ If no, when did you quit? ____________

Have you had a colonoscopy in the last 5 years? Yes ☐ / No ☐

Do you have an Advanced Care Plan in place? Yes ☐ / No ☐ /No ☐ (my cultural and/or spiritual beliefs preclude me from having a discussion regarding advance care planning)

If yes… ☐ Living Will ☐ Do Not Resuscitate ☐ Power of Attorney

REVIEW OF SYSTEMS

Do you or have you recently had any problems related to the following?
Please circle **Y** for Yes or **N** for No. If your answer is Yes, please explain in the space provided.

Name: ___________________________________ **DOB:** ______________

Constitutional

Fever	Y	N
Chills	Y	N
Weight Loss	Y	N
Other ___________________________		

Eyes

Blurred vision	Y	N
Glaucoma	Y	N
Other ___________________________		

Ears/Nose/Throat

Difficulty hearing	Y	N
Sinus problems	Y	N
Difficulty swallowing	Y	N
Other ___________________________		

Respiratory

Shortness of breath	Y	N
Chronic cough	Y	N
Other		

Cardiovascular

Chest pain	Y	N
Heart attack	Y	N
High blood pressure	Y	N
Other ___________________________		

Genitourinary

Frequent urination	Y	N
Wake to urinate	Y	N
# of times _______		
Slow stream	Y	N
Push to urinate	Y	N
Retaining urine	Y	N
Painful urination	Y	N
Urinary tract infection	Y	N
Incontinence	Y	N
# of pads per day _______		
Sexual activity	Y	N
Low libido	Y	N
Difficulty reaching orgasm	Y	N
Pain with intercourse	Y	N
Vaginal dryness	Y	N
Other ___________________________		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Constipation/diarrhea	Y	N
Other ___________________________		

Musculoskeletal/Neck

Back pain	Y	N
Leg pain	Y	N
Muscle pain	Y	N
Other ___________________________		

Neurological

Migraines	Y	N
Dizzy spells (Lightheadedness)	Y	N
Numbness/tingling	Y	N
Other ___________________________		

Integumentary

Skin rash	Y	N
Skin lesion(s)	Y	N
Breast (lumps, etc.)	Y	N
Other ___________________________		

Allergic/Immunologic

Hay fever	Y	N
Environmental allergies	Y	N
Food allergies	Y	N
Other ___________________________		

Hematologic/Lymphatic

Blood clotting disorder	Y	N
Anemia	Y	N
Swollen glands	Y	N
Other ___________________________		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other		

Psychological

Depression	Y	N
Anxiety	Y	N
Other ___________________________		

_____________________________________ _________________________

Physician Signature Date