Dr. Gabal, M.D.

MRN: _____

Date: _____

Patient Name: _____

Date of Birth: ____/____/_____ Age: _____

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced

Occupation (current or former):_____

CHIEF COMPLAINT:

What is the main reason for your visit today? (Please describe in detail)

_____

_____

_____

HISTORY OF PRESENT ILLNESS:

Location of Problem: ☐Abdomen ☐Back ☐Genitals ☐Other: _____	How long does the problem last? ☐30 minutes ☐ 1 day ☐ Always there ☐Other:_____
On a scale of 1-10, with 10 being the most severe, circle the number that best describes your problem: 1 2 3 4 5 6 7 8 9 10	Is there anything else occurring at the same time? ☐Yes ☐No If Yes, explain:_____ ☐Nausea ☐Rash ☐Headache ☐Other: _____
When did you first notice the problem? ☐2 days ago ☐1weeks ago ☐1 month ago ☐Other: _____	Is the problem constant or variable? ☐Dull, then sharp ☐Sharp, then leaves ☐Always there ☐Other: _____
	Does the problem interfere with your normal function? ☐Yes ☐No If yes, explain: _____ _____ _____

Physician Use Only (Comments and Notes)

Lamia L. Gabal-Shehab MD Inc. Patient Signature: _____ Date: _____

Dr. Gabal, M.D.

Patient Name: _____

Date of Birth: ____/____/_____ Age: _____

MRN: _____

Date: _____

MY MAIN PROBLEMS ARE:

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

ALLERGIES:

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

MEDICATIONS:

☐None ☐Aspirin ☐Lortab ☐Percocet ☐Plavix ☐Nitroglycerin
☐Detrol ☐Detrol LA ☐Vesicare ☐Allopurinol ☐Coumadin
☐Antibiotics: ☐Other:

SURGICAL HISTORY:

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

MEDICAL HISTORY:

☐Hepatitis ☐Diabetes ☐Emphysema ☐Heart Attack ☐Heart Murmur
☐Parkinson's ☐Hernia ☐Hypertension ☐Last Period: ____ ☐Menopause
☐No Changes ☐Other:_____ ☐Pregnant ☐Stroke ☐Cancer:_____

FAMILY HISTORY: ☐Kidney Cancer ☐Kidney Stones ☐Heart Disease

MY SYMPTOMS 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 Pain	☐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 SYMPTOMS ARE:

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

Lamia L. Gabal-Shehab MD Inc. Patient Signature: _____ Date: _____