

PRINCE WILLIAM UROLOGY ASSOCIATES, LTD

Ali M Sajadi, MD - Andrew K Chung, MD - Amy K Moreno, MD - Anshu Guleria, MD

New Patient Urologic History Form

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

Age: _____ DOB: _____ Referring Dr: _____ Primary Dr: _____

Allergies: Are you allergic to:

- | | | |
|--|--|---|
| <input type="checkbox"/> Latex | <input type="checkbox"/> Iodine/Betadine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Dye/IV Contrast | <input type="checkbox"/> Tape/Adhesives | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Shellfish/Shrimp! | <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Cipro/Levaquin |

I have no medication

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

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:

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

_____ |
|---|--|--|

Female history

Number of pregnancies: _____ Number of Deliveries: _____ Vaginal C-Section
 Have you had a hysterectomy? Yes No When? ____ Why? _____
 Have you had any prior bladder surgeries/when? _____
 Have you had a bladder tack/when? _____
 Have you had a sling/when? _____

Surgical History

Date	Surgery	Date	Surgery

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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: _____

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? (You may choose more than one location)

- | | | |
|----------------------------------|---------------------------------|------------------------------------|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Flank |
| <input type="checkbox"/> Back | <input type="checkbox"/> Penis | <input type="checkbox"/> Bladder |
| <input type="checkbox"/> Groin | <input type="checkbox"/> Rectum | <input type="checkbox"/> Genitalia |

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

How long does the problem last? _____

Is the problem: Constant Variable Seldom

Does anything make the problem worse?

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Moving around | <input type="checkbox"/> Standing up |
| <input type="checkbox"/> Lying on side | <input type="checkbox"/> Other: _____ |

Does anything make the problem better? _____

Does the problem interfere with your normal activities? Yes No

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What testing have you had to evaluate your urological problem?

- I have had no tests to evaluate this problem
- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> X-ray | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Urodynamic Testing |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> Nuclear bone scan | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Nuclear renal scan | <input type="checkbox"/> Unsure |
| <input type="checkbox"/> IVP | <input type="checkbox"/> Urine specimen | |
| <input type="checkbox"/> Blood tests | <input type="checkbox"/> Cystoscopy | |

Where was the test performed? _____

Do you have blood in the urine? Yes No If no, have you ever had blood in the urine? Yes No

If yes:

- | | | |
|---|--|--|
| <input type="checkbox"/> Every time I urinate | <input type="checkbox"/> It occurs at the beginning of urination | <input type="checkbox"/> It occurs the entire urine stream |
| <input type="checkbox"/> Intermittently | <input type="checkbox"/> It occurs at the end of urination | <input type="checkbox"/> Blood clots are passed in the urine |
| <input type="checkbox"/> Painful | | |
| <input type="checkbox"/> Painless | | |

Do you experience any of the following?

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Urinary urgency | <input type="checkbox"/> Weak stream | <input type="checkbox"/> Dribbling |
| <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Straining to urinate | |
| <input type="checkbox"/> Burning with urination | <input type="checkbox"/> Trouble starting stream | |

How many times do you wake up to urinate at night? 0 1 2 3 4 5 6 7 8 9 10

Do you feel like your emptying your bladder completely? Yes No

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

How many Pads/day? _____ Liners/day? _____ Diapers/day? _____ Other: _____

Are they usually: Dry Moist Wet Soaked

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15195 Heathcote Blvd, Suite 330, Haymarket, VA 20169-6244
Phone: (703) 393-0700; Fax: 703-393-0661

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Men only:

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

Please indicate which medication(s) below:

Viagra Cialis Levitra Staxyn MUSE BiMix TriMix VED Other: _____

Men & Women:

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

(Please explain:) _____

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