

MRN:

Patient Name:

Date of Birth: \_

\_

/

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Age:

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced

Occupation (current or former):

Date:

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 ☐ Alwaysthere * 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? | Is the problem constant or variable? |
| * 2 days ago ☐1weeks ago ☐1 month ago | * Dull, then sharp ☐Sharp, thenleaves |
| * Other: | * Always there |
|  | * Other: |
|  | Does the problem interfere with your normal function?   * Yes ☐No   If yes,explain: |

Physician Use Only (Comments and Notes)

Patient Signature: Date:

Complaint Female Form



MRN:

Patient Name:

Date of Birth: \_

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Age:

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 * Lithotripsy * No Changes | * Appendectomy * Gallbladder * Sling (TVT) | * Back/Hip/Knee * Heart Bypass * Vaginal Deliveries | * Bladder Tack * Hysterectomy #\_ | * C-Section #\_ * Kidney Stone surgery * 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 #

Patient Signature: Date:

Complaint Female Form