

MRN:

Patient Name:

Date of Birth: \_

\_

/

/

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: \_

\_

/

/

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