

Patient Name:

Date of Birth: \_

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Age:

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced

Occupation (current or former):

MRN:

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 Male Form



MRN:

Patient Name:

Date of Birth: \_

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Age:

Date:

MY MAIN PROBLEMS ARE:

* Enlarged Prostate ☐Blood in Urine ☐High PSA ☐Bladder Infection
* Kidney Stones ☐Prostate Infection ☐Urinary Incontinence ☐Bladder Cancer
* Prostate Cancer ☐Erectile Dysfunction ☐Overactive Bladder ☐Infertility
* Lump in Testicle ☐Other:

ALLERGIES:

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

MEDICATIONS: (PLEASE LIST ALL CURRENT MEDICATIONS)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SURGICAL HISTORY: |  | | | |
| * Heart Bypass | * Appendectomy | * Back/Hip/Knee | * Cystoscopy | * Gallbladder |
| * Prostate | * Kidney Stone Surgery | * Lithotripsy | * Prostate Biopsy | * Prostate Seed |

* No Changes ☐Other:

MEDICAL HISTORY:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Hepatitis | * Diabetes | * Emphysema | * Heart Attack | * Heart Murmur |
| * No Changes | * Hernia | * Hypertension | * Parkinson’s | * Stroke |
| Cancer: ☐Prostate | * Kidney | * Testis | * Other: |  |

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

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:

* Incomplete Emptying ☐Frequency ☐Intermittency ☐Straining ☐Weak Stream
* Testicle Pain ☐Pain in Side R/L ☐Urinating at Night #

Patient Signature: Date:

Complaint Male Form