

Patient Name:

Date of Birth: \_

\_

/

/

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