

Patient Name: _____ SS# _____

Referring Physician: _____ Office location: _____

Your Age: _____ Date of Birth: ____/____/____

Please write in your own words the reason for this visit: _____

URINARY SYMPTOMS

Do you have significant:

- Burning/pain when passing urine Incomplete emptying Bed wetting
- Wake up with strong urge to void Lose urine before reaching toilet
- Recurrent bladder infections Dribbling after voiding Bloody urine
- Have to hurry to toilet urinary frequency slow stream

Number of times you pass urine at night: _____

Number of times you pass urine during the day: _____

Do you lose urine? Yes No

When did the leakage start? _____

Do you wear any protection? Yes No If yes, what type? _____

How often does this leaking occur?

- Daily
- Weekly
- Monthly
- Less than monthly

How much urine do you lose?

- A drop or two
- Enough to change undergarments
- Enough to wet outer clothes

Under what circumstances does leakage occur:

- Coughing Sneezing Lifting Bending Laughing
- Aerobics Bowling With Sex Sound of running water exercise
- Getting up Other: _____

Previous medical therapy for urinary problems: _____

Previous surgical therapy for urinary problems:

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MEDICATIONS:

Please list all medications including street drugs and over the counter drugs.

Drug	Strength	How often do you take it?

PREVIOUS SURGERY or HOSPITALIZATIONS (Other than childbirth)

YEAR	Type of Surgery or reason for Hospitalization

SOCIAL HISTORY

Current Marital status: ___ Married ___ Single ___ Divorced/separated ___ Widowed

Living with: _____

Occupation: _____

Activity or Habits	Yes	NO	How much or how often?
Do you smoke?			
Coffee, tea or soda?			
Do you drink alcohol?			
Do you use street drugs?			
Do you exercise regularly?			

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FAMILY HISTORY: Has anyone in your family had any of these diseases? If so, give the relationship.

High blood pressure _____ Diabetes _____ Kidney disease _____

Stroke _____ Breast cancer _____

Heart disease _____ Thyroid disease _____

Other cancer _____

Other conditions: _____

REVIEW OF SYMPTOMS: Please circle if this is currently a problem.

Change in bowel habits

Indigestion

Constipation

Diarrhea

Fecal soiling

Black or bloody stools

Difficulty in swallowing

Vomiting blood

Skin rashes

Skin infection

Change in mole

Acne

Loss of hair

Abnormal hair growth

Itching skin

Headaches

Dizziness

Ear pain/infection

Visual changes

Decreased Hearing

Throat/Sinus infection

Difficulty speaking

Blood thinners

Recent Steroid use

Change breast size

Breast Lumps

Nipple discharge

Breast pain

Change in appetite

Weight loss

Weight gain

Hemorrhoids

Fainting

Trouble breathing

Productive cough

Cough up blood

Chest pain

Exposure TB

Heart murmur

Chest X-ray

Swelling of legs

Varicose Veins

Pulmonary embolism

Joint pain/swelling

fever/chills

Sweating at night

Hot Flashes

Anemia

Easy bruising

Prolonged bleeding

Bleeding gums

Bloody nose

Enlarged thyroid

Intolerance to heat

Excessive thirst

Insomnia

Tremors

Depression

Weakness

Fatigue

Nervousness

Thoughts of suicide

Ringing in ears

Hoarseness

Convulsions/Seizures

Sores in mouth