

MRN: _____

Date: _____

Patient Name: _____

Date of Birth: ___/___/_____ Age: _____

Marital Status: Married Single Widowed Divorced

Occupation (current or former): _____

CHIEF COMPLAINT:

What is the main reason for your visit today? (Please describe in detail)

HISTORY OF PRESENT ILLNESS:

<p>Location of Problem: <input type="checkbox"/> Abdomen <input type="checkbox"/> Back <input type="checkbox"/> Genitals <input type="checkbox"/> Other: _____</p>	<p>How long does the problem last? <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 day <input type="checkbox"/> Always there <input type="checkbox"/> Other: _____</p>
<p>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</p>	<p>Is there anything else occurring at the same time? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain: _____ <input type="checkbox"/> Nausea <input type="checkbox"/> Rash <input type="checkbox"/> Headache <input type="checkbox"/> Other: _____</p>
<p>When did you first notice the problem? <input type="checkbox"/> 2 days ago <input type="checkbox"/> 1 weeks ago <input type="checkbox"/> 1 month ago <input type="checkbox"/> Other: _____</p>	<p>Is the problem constant or variable? <input type="checkbox"/> Dull, then sharp <input type="checkbox"/> Sharp, then leaves <input type="checkbox"/> Always there <input type="checkbox"/> Other: _____</p>
	<p>Does the problem interfere with your normal function? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____</p>

Physician Use Only (Comments and Notes)

Patient Signature: _____ Date: _____

MRN: _____

Date: _____

Patient Name: _____

Date of Birth: ___/___/_____ Age: _____

MY MAIN PROBLEMS ARE:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Bladder Pain |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Leak Urine | <input type="checkbox"/> Overactive Bladder |
| <input type="checkbox"/> Dropper Bladder | <input type="checkbox"/> Other: _____ | | |

ALLERGIES:

- | | | | | |
|---------------------------------------|------------------------------|--------------------------------|--------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> PCN | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Cipro | <input type="checkbox"/> Iodine/Contract |
| <input type="checkbox"/> Other: _____ | | | | |

MEDICATIONS:

- | | | | | | |
|---------------------------------------|------------------------------------|-----------------------------------|--------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Lortab | <input type="checkbox"/> Percocet | <input type="checkbox"/> Plavix | <input type="checkbox"/> Nitroglycerin |
| <input type="checkbox"/> Detrol | <input type="checkbox"/> Detrol LA | <input type="checkbox"/> Vesicare | <input type="checkbox"/> Allopurinol | <input type="checkbox"/> Coumadin | |
| <input type="checkbox"/> Antibiotics: | | <input type="checkbox"/> Other: | | | |

SURGICAL HISTORY:

- | | | | | |
|--------------------------------------|---------------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Back/Hip/Knee | <input type="checkbox"/> Bladder Tack | <input type="checkbox"/> C-Section # _____ |
| <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Kidney Stone surgery |
| <input type="checkbox"/> No Changes | <input type="checkbox"/> Sling (TVT) | <input type="checkbox"/> Vaginal Deliveries # _____ | <input type="checkbox"/> Other: _____ | |

MEDICAL HISTORY:

- | | | | | |
|--------------------------------------|---------------------------------------|---------------------------------------|---|--|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Hernia | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Last Period: _____ | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> No Changes | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer: _____ |

FAMILY HISTORY: Kidney Cancer Kidney Stones Heart Disease

MY SYMPTOMS ARE:

- | | | | |
|---------------------------|--|---|--|
| General/Constitutional | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Chills |
| Eyes | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Cataracts |
| Ears, Nose, Mouth, Throat | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Nasal Stuffiness | <input type="checkbox"/> Sore Throat |
| Cardiovascular | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Irregular Heartbeat |
| Respiratory | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Chronic Cough |
| Gastrointestinal | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Change in Bowels |
| Genitourinary | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine |
| Musculoskeletal | <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Chronic Neck Pain | <input type="checkbox"/> Sore Muscles |
| Integumentary/Skin | <input type="checkbox"/> Rash | <input type="checkbox"/> Persistent Itching | <input type="checkbox"/> Skin Cancer History |
| Neurologic | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Dizziness |
| Hematologic/Lymphatic | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Transfusion History |

URINARY SYMPTOMS ARE:

- | | | | | |
|---------------------------------------|---|---|---|---|
| <input type="checkbox"/> Frequency | <input type="checkbox"/> Urgency | <input type="checkbox"/> Leakage | <input type="checkbox"/> Straining | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Bladder Pain | <input type="checkbox"/> Pain in Side R/L | <input type="checkbox"/> Not Emptying Bladder | <input type="checkbox"/> Urinating at Night # _____ | |

Patient Signature: _____ Date: _____