PRESTIGE MEDICAL GROUP

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:

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? ☐ 2 days ago ☐1weeks ago ☐1 month ago ☐ Other: _____	Is the problem constant or variable? ☐ Dull, then sharp ☐Sharp, thenleaves ☐ 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: _____

_____

PRESTIGE MEDICAL GROUP

MRN: _____

Date: _____

Patient Name: _____

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

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: _____