

			/ /	/ /
Last Name	First Name	M.I	date of birth	today's date

HISTORY OF PRESENT ILLNESS

Whom may we thank for referring you to UANT? Self Friend Physician _____

Primary Care Physician _____ Previous Urologist _____

What is the main reason for your visit:

<input type="radio"/> Elevated PSA	<input type="radio"/> Blood in urine <input type="radio"/> Visible <input type="radio"/> invisible	<input type="radio"/> BPH or male voiding symptoms	<input type="radio"/> Incontinence or female voiding symptoms
<input type="radio"/> Erectile dysfunction	<input type="radio"/> Kidney stones	<input type="radio"/> Urinary tract infections	<input type="radio"/> History of prostate cancer
<input type="radio"/> History of bladder cancer	<input type="radio"/> History of kidney cancer	<input type="radio"/> Infertility	<input type="radio"/> Abdominal or flank pain
<input type="radio"/> Vasectomy	<input type="radio"/> Other Specify		

What is the approximate date when the symptoms started or you first became aware of the problem?

/ / or _____ days weeks months years ago
date number (circle one)

Describe any previous treatment (medicines, surgery, etc) prior to this visit for the problem:

Complete the following section if the reason for today's visit is for voiding problems (male or female):

How many times during the day do you typically void in the toilet or urinal?	_____	
How many times do you typically get out of bed at night to urinate?	_____	
Do you have difficulty starting your urinary stream?.....	Yes	No
Do you have decreased force in your stream?.....	Yes	No
Do you have to strain or push to void?	Yes	No
Do you still feel full when you have finished voiding?	Yes	No
Does your stream typically stop and start during voiding?.....	Yes	No
Do you typically have pain during voiding?.....	Yes	No
Have you seen blood in your urine?	Yes	No

Complete the following section if the reason for today's visit is for incontinence (male or female):

How many episodes of incontinence do you have in a typical daytime period?	_____	
How many episodes of incontinence do you have in a typical nighttime period?	_____	
Are you incontinent with.....	Coughing?	Yes No
	Sneezing?.....	Yes No
	Walking?.....	Yes No
	Physical activity?.....	Yes No
Are you bothered by a need to hurry to get to the bathroom?.....	Yes	No
Are you incontinent because you cannot get to the bathroom in time?.....	Yes	No
Do you wear pads to manage incontinence?	Yes	No
	If yes, type of pad _____	
	# pads per day _____	
	# pads per night _____	
Last treatment for a urinary tract infection.....	/ /	
Do you have	Diabetes?	Yes No
	Stroke or head injury?	Yes No
	Back injury or surgery?	Yes No
	Past radiation therapy?	Yes No
	Weak or numb legs?	Yes No
	Incontinence of stool?	Yes No
(WOMEN ONLY)	number of pregnancies/deliveries	_____ / _____

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MEDICAL HISTORY

CURRENT MEDICATIONS (include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or circle **NONE**

Name of Medication	Dose (mg)	How often is the medication taken	Reason for taking medication	Physician prescribing
1				
2				
3				
4				
5				
6				
7				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name:	Phone #:	Fax #:
Address:	City	State/Zip:

ALLERGIES (include medications, foods, xray dyes) or circle **NONE KNOWN**

Name of allergen	Type of reaction	Approximate date
1		
2		
3		
4		

PAST SURGERIES (include all surgery in your lifetime. Attach extra sheet if necessary) or **NONE**

Type of Surgery	Date (approximate)	Hospital or city if known
1		
2		
3		
4		
5		
6		
7		
8		

OTHER HOSPITALIZATIONS (include all non surgical hospitalizations) or circle **NONE**

Reasons for Hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		
4		
5		
6		
7		

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MEDICAL HISTORY (cont'd)

MEDICAL CONDITIONS (include past and present medical conditions, check appropriate box)

Condition	NO	Past (Resolved)	Now Active	Date Onset	Specialist MD if applicable
High Blood pressure (hypertension)					
Elevated cholesterol					
Heart attack					
Irregular heart beat (cardiac arrhythmia)					
Congestive heart failure					
Stroke or TIAs					
Ulcers of the stomach or intestine					
Emphysema, COPD, or lung problems					
Asthma					
Diabetes					
Bleeding problems					
HIV/AIDS					
Kidney disease (renal failure)					
Liver disease (hepatitis B or C)					
Seizures					
Thyroid disease					
Psychological or psychiatric disease					
Cancer of any organ (specify)					
Kidney stones					
Glaucoma					
List other conditions					

FAMILY HISTORY

Is there a history in your family of	No	Yes	Affected relative(s)
Heart attack			
Diabetes			
Prostate cancer			
Kidney cancer			
Kidney stones			
Other significant disease			

TOBACCO HISTORY

Are you an active cigarette smoker?	Yes	No
Have you ever been a cigarette smoker?	Yes*	No
* If yes, I smoked an average of _____ packs/day for _____ years. I quit in _____ (year)		
Do you use other tobacco products	Yes	No
If yes, please specify _____		

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism?	Yes	No
Do you currently drink alcohol regularly <input type="checkbox"/> Yes, currently <input type="checkbox"/> Never/rarely		
If yes, approximately how many drinks per week (beer, wine, or liquor) _____		
Have you ever used intravenous drugs?	Yes	No

OCCUPATION AND MARITAL STATUS

I am currently	<input type="checkbox"/> single	<input type="checkbox"/> married	<input type="checkbox"/> divorced	<input type="checkbox"/> widowed
I am	<input type="checkbox"/> retired	<input type="checkbox"/> employed full time	<input type="checkbox"/> employed part time	<input type="checkbox"/> unemployed <input type="checkbox"/> student
My occupation is/was _____				

