USMD | UANT
A USMD AFFILIATE

# HISTORY OF PRESENT ILLNESS



Today's Date: _____

_____ _____ _____ _____/_____/_____
Last Name First Name M.I. D.O.B.

Whom may we thank for referring you to USMD | UANT? ☐ Self ☐ Friend ☐ Physician:_____

Primary Care Physician: _____ Previous Urologist: _____

What is the main reason for your visit:

☐ Elevated PSA
☐ Erectile dysfunction
☐ History of bladder cancer
☐ Vasectomy
☐ Blood in urine ☐ Visible ☐ Invisible
☐ Kidney stones
☐ History of kidney cancer
☐ BPH or male voiding symptoms
☐ Urinary tract infections
☐ Infertility
☐ Incontinence or female voiding symptoms
☐ History of prostate cancer
☐ Abdominal or flank pain
☐ Other Specify_____

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

Date: _____/_____/_____ or _____ ☐ days ☐ weeks ☐ months ☐ years ago

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 date 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?_____/ _____

## 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 circle **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 | | |

# HISTORY OF PRESENT ILLNESS



## 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? ☐ Yes, currently ☐ 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: ☐ single ☐ married ☐ divorced ☐ widowed

I am: ☐ retired ☐ employed full time ☐ employed part time ☐ unemployed ☐ student

My occupation is/was: _____

## REVIEW OF SYSTEMS

(Current or Recent Symptoms)

**Constitutional**

| | | |
|---|---|---|
| Chills | ☐Yes | ☐No |
| Fever | ☐Yes | ☐No |
| Headache | ☐Yes | ☐No |
| Weight gain over 10 lbs | ☐Yes | ☐No |
| Weight loss over 10 lbs | ☐Yes | ☐No |

**Neurological (nervous system)**

| | | |
|---|---|---|
| Dizziness | ☐Yes | ☐No |
| Frequent falls | ☐Yes | ☐No |
| Loss of balance | ☐Yes | ☐No |
| Numbness in extremity | ☐Yes | ☐No |
| Seizures | ☐Yes | ☐No |
| Tremors | ☐Yes | ☐No |
| Weakness in extremity | ☐Yes | ☐No |

**Endocrine (internal glands)**

| | | |
|---|---|---|
| Cold or heat intolerance | ☐Yes | ☐No |
| Excessive fatigue | ☐Yes | ☐No |
| Excessive thirst | ☐Yes | ☐No |
| Thyroid disease | ☐Yes | ☐No |

**Gastrointestinal**

| | | |
|---|---|---|
| Abdominal pain | ☐Yes | ☐No |
| Blood in stools | ☐Yes | ☐No |
| Constipation | ☐Yes | ☐No |
| Diarrhea | ☐Yes | ☐No |
| Indigestion/Heartburn | ☐Yes | ☐No |
| Nausea vomiting | ☐Yes | ☐No |

**Cardiovascular**

| | | |
|---|---|---|
| Calf pain with exercise | ☐Yes | ☐No |
| Chest pain, pressure | ☐Yes | ☐No |
| Palpitations | ☐Yes | ☐No |
| Shortness of breath | ☐Yes | ☐No |
| Swelling in legs/ankles | ☐Yes | ☐No |
| Wake up breathless | ☐Yes | ☐No |

**Integumentary (skin problems)**

| | | |
|---|---|---|
| Frequent boils | | |
| Unexplained rash | ☐Yes | ☐No |

**Musculoskeletal**

| | | |
|---|---|---|
| Back pain | ☐Yes | ☐No |
| Recent or Chronic | | |
| Joint pain | ☐Yes | ☐No |
| Which joint_____ | | |
| Muscle weakness | ☐Yes | ☐No |
| Neck pain | ☐Yes | ☐No |

**Respiratory (lungs)**

| | | |
|---|---|---|
| Coughing up blood | ☐Yes | ☐No |
| Frequent coughing | ☐Yes | ☐No |
| Shortness of breath | ☐Yes | ☐No |
| Wheezing | ☐Yes | ☐No |

**Hematologic/Lymphatic**

| | | |
|---|---|---|
| Bleeding tendency | ☐Yes | ☐No |
| Swollen lymph glands | ☐Yes | ☐No |

**Genitourinary (urinary and genital)**
***(Complete only if not reason for visit)***

| | | |
|---|---|---|
| Blood in urine | ☐Yes | ☐No |
| Erectile dysfunction | ☐Yes | ☐No |
| Frequent urination | ☐Yes | ☐No |
| Incomplete emptying | ☐Yes | ☐No |
| Incontinence | ☐Yes | ☐No |
| Interrupted urine flow | ☐Yes | ☐No |
| Painful urination | ☐Yes | ☐No |
| Straining to urinate | ☐Yes | ☐No |
| Urgent urination | ☐Yes | ☐No |
| Weak urine stream | ☐Yes | ☐No |

**Eyes**

| | | |
|---|---|---|
| Blurred vision | ☐Yes | ☐No |
| Double vision | ☐Yes | ☐No |
| Eye pain | ☐Yes | ☐No |
| History glaucoma | ☐Yes | ☐No |
| Retinal disease | ☐Yes | ☐No |
| Untreated cataracts | ☐Yes | ☐No |

**Ear/Nose/Throat/Mouth**

| | | |
|---|---|---|
| Difficulty swallowing | ☐Yes | ☐No |
| Ear infections | ☐Yes | ☐No |
| Hearing loss | ☐Yes | ☐No |
| Hoarseness | ☐Yes | ☐No |
| Nose bleeds | ☐Yes | ☐No |
| Sinus allergies | ☐Yes | ☐No |
| Sore throat | ☐Yes | ☐No |

**Psychological**

| | | |
|---|---|---|
| Depression | ☐Yes | ☐No |
| Loss of general interest | ☐Yes | ☐No |
| Severe anxiety | ☐Yes | ☐No |

**Height (inches)** _____

**Weight (lbs)** _____

_____

Signature

_____

Date