Name: _____ Date: _____

Please complete the following form. It will allow us to expedite your visit and spend time on your urologic problem. Please list:

Any current illnesses:

Prior urologic or major surgeries:

Present medications:

Allergies to medications:

Significant family illnesses:

Social history: Marital status_____ Do you smoke? _____
Do you drink alcohol? _____ How many drinks per day? _____

Do you now, or have you ever had any problems related to the following systems?
Please circle yes or no. Please explain any yes answers in the space provided below.

| | | | | | |
|---|---|---|---|---|---|
| **Constitutional Symptoms:** | | | **Integumentary:** | | |
| Weight loss | Y | N | Boils | Y | N |
| Headache | Y | N | Persistent Itch | Y | N |
| Chills | Y | N | Other_____ | | |
| Other_____ | | | **Musculoskeletal:** | | |
| **Eyes:** | | | Joint pain | | |
| Blurred vision | Y | N | Neck pain | Y | N |
| Double vision | Y | N | Back pain | Y | N |
| Pain | Y | N | Other_____ | | |
| Other | | | **Genitourinary:** | | |
| **Neurological:** | | | Urinary retention | Y | N |
| Tremors | Y | N | Kidney stones | Y | N |
| Dizzy spells | Y | N | Impotence | Y | N |
| Numbness/Tingling | Y | N | Urinary infection | Y | N |
| Other_____ | | | Other_____ | Y | N |
| **Endocrine:** | | | **Respiratory:** | | |
| Excessive thirst | Y | N | Wheezing | Y | N |
| Too hot/cold | Y | N | Cough | Y | N |
| Tired/sluggish | Y | N | Shortness of breath | Y | N |
| Other_____ | | | Other_____ | | |
| **Gastrointestinal:** | | | **Hematologic/Lymphatic:** | | |
| Abdominal pain | Y | N | Swollen glands | Y | N |
| Nausea/vomiting | Y | N | Blood clotting problem | Y | N |
| Indigestion/heartburn | Y | N | Other_____ | | |
| Other_____ | | | | | |
| **Cardiovascular:** | | | | | |
| Chest pain | | | | | |
| Varicose veins | Y | N | | | |
| High blood pressure | Y | N | | | |
| Other_____ | | | | | |
| **Allergy/Immunologic:** | | | | | |
| Hay fever | Y | N | | | |
| Food allergies | Y | N | | | |
| Other_____ | | | | | |