UROLOGY™
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150 Broadhollow Road, Suite 306, Melville, New York 11747 – Tel. (631) 629-4949, Fax (631) 629-4948
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**Date**: _____

**First Name**: _____ **M.I.**: _____ **Last Name:** _____
**DOB**: _____ **Gender:** □ **Male** □ **Female**
**Occupation:** _____

## Reason for your visit

_____
_____

Date when it first occurred? _____
Is the problem present? □ **all the time** □ **on and off**
Length problem lasts each time: ___ □ **Hours** □ **Days** □**Weeks** □ **Months**
The pain severity is (out of 10): □ **1** □ **2** □ **3** □ **4** □ **5** □ **6** □ **7** □ **8** □ **9** □ **10**
Anything else occurs at the same: □ **No** □ **Yes** Describe: _____
_____
_____

Position that relieves or worsens problem: _____
Activities that relieve or worsen problem: _____
Interferes with daily functions? □ No □ Yes _____

## Medical and Surgical History

### Medical Condition:

**Diabetes:** □ **No** □ **Yes**
**High Blood Pressure:** □ **No** □ **Yes**
**Heart Attack:** □ **No** □ **Yes**
**Heart Valve Disease:** □ **No** □ **Yes**
**Kidney Cancer:** □ **No** □ **Yes**
**Bladder Cancer:** □ **No** □ **Yes**
**Prostate Cancer:** □ **No** □ **Yes**
**Other Cancer:** □ **No** □ **Yes**
**Describe:**_____ _____
**Urinary Incontinence:** □ **No** □ **Yes**
**Urinary Tract Infections:** □ **No** □ **Yes**
**Kidney Stones:** □ **No** □ **Yes**
**Asthma:** □ **No** □ **Yes**

### Surgery:

**Appendix:** □ **No** □ **Yes** **Date:**_____
**Gallbladder:** □ **No** □ **Yes** **Date:**_____
**Hysterectomy:** □ **No** □ **Yes** **Date:**_____
**Cesarean Section:** □ **No** □ **Yes** **Date:**_____
**Open Heart (Bypass)** □ **No** □ **Yes** **Date:**_____
**Heart Valve:** □ **No** □ **Yes** **Date:**_____
**Shoulder / Knee/ Hip:** □ **No** □ **Yes** **Date:**_____
**Prostate Cancer:** □ **No** □ **Yes** **Date:**_____
**Prostate Enlargement:** □ **No** □ **Yes** **Date:**_____
**Kidney Cancer:** □ **No** □ **Yes** **Date:**_____
**Kidney Stones:** □ **No** □ **Yes** **Date:**_____
**Bladder Cancer:** □ **No** □ **Yes** **Date:**_____
**Bladder Stones:** □ **No** □ **Yes** **Date:**_____

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## Medical and Surgical History (Continued)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **COPD:** | □ **No** | □ **Yes** | **Small Intestine:** | □ **No** | □ **Yes** | **Date:**_____ |
| **Hypothyroid:** | □ **No** | □ **Yes** | **Large Intestine: (colon):** | □ **No** | □ **Yes** | **Date:**_____ |
| **Hyperthyroid:** | □ **No** | □ **Yes** | **Stomach:** | □ **No** | □ **Yes** | **Date:**_____ |
| **Glaucoma:** | □ **No** | □ **Yes** | **Hernia:** | □ **No** | □ **Yes** | **Date:**_____ |
| **Neurological Disorder:** | □ **No** | □ **Yes** | | | | |
| **Recent weight loss:** | □ **No** | □ **Yes** | | | | |
| **High Cholesterol:** | □ **No** | □ **Yes** | | | | |

## MEDICATIONS

**List all Medications you currently take and the dosage:**

**Name / Reason for taking it / Dosage**

_____

_____

_____

_____

_____

_____

## ALLERGIES

Allergic to antibiotics? □ **No** □ **Yes** **If yes, to which?** _____

Allergic to other medications? □ **No** □ **Yes** **If yes, to which?** _____

Allergic to latex? □ **No** □ **Yes** _____

Allergic to dye/ shellfish? □ **No** □ **Yes** _____

### Please <u>CIRCLE</u> the number that best applies to you for each question below:

| Over the last month or so: | Not at all | Less than 1 time in 5 | Less than ½ the time | About ½ the time | More than ½ the time | Almost always |
|---|---|---|---|---|---|---|
| Sensation of not emptying your bladder completely after urinating: | **0** | **1** | **2** | **3** | **4** | **5** |

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**Please CIRCLE the number that best applies to you for each question below (Continued):**

| | | | | | | |
|---|---|---|---|---|---|---|
| Had to urinate again less than 2 hours after finished urinating: | **0** | **1** | **2** | **3** | **4** | **5** |
| Stopped and started again several times when urinating: | **0** | **1** | **2** | **3** | **4** | **5** |
| Difficult to postpone urination: | **0** | **1** | **2** | **3** | **4** | **5** |
| Weak urinary Stream: | **0** | **1** | **2** | **3** | **4** | **5** |
| Had to push or strain to urinate: | **0** | **1** | **2** | **3** | **4** | **5** |
| How many times got up to urinate at night, after going to bed? | **0** | **1** | **2** | **3** | **4** | **5** |

## Social History

### Tobacco Use

□ **Yes –** Packs per day: □ **1** □ **2** □ **3** □ **4** □ **5**
□ **No** – Previous packs per day: □ **1** □ **2** □ **3** □ **4** □ **5** **Stopped on:** _____
□ **Never**
Comments:_____

### Alcohol Use

□ **Yes.** □ **Insignificant** □ **Previous** **Drinks per day:** _____
□ **No. Stopped on:** _____
□ **Never**
Comments: _____

### Caffeine Use

□ **Yes** □ **Insignificant** □ **Previous** **Cups per day:** _____
Previous Cups per day: _____ Stopped: _____
Comments: _____

### Illicit Drugs

□ **Yes** □ **Never** □ **Previous**
Type: _____
_____

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## FAMILY HISTORY

| | | | | | |
|---|---|---|---|---|---|
| **Diabetes:** | ☐ **No** | ☐ **Yes** | **Kidney Stones:** | ☐ **No** | ☐ **Yes** |
| **High Blood Pressure:** | ☐ **No** | ☐ **Yes** | **Enlarged Prostate:** | ☐ **No** | ☐ **Yes** |
| **Heart Disease:** | ☐ **No** | ☐ **Yes** | **Infertility:** | ☐ **No** | ☐ **Yes** |
| **Kidney Cancer:** | ☐ **No** | ☐ **Yes** | **Neurological Disorder:** | ☐ **No** | ☐ **Yes** |
| **Bladder Cancer:** | ☐ **No** | ☐ **Yes** | **Psychiatric Disorder:** | ☐ **No** | ☐ **Yes** |
| **Prostate Cancer:** | ☐ **No** | ☐ **Yes** | | | |
| **Other Cancer:** | ☐ **No** | ☐ **Yes** | | | |

**Describe other:** _____

## Review of Systems:

**Have you ever experienced any recent or chronic problems related to the following systems? Please check appropriately.**

| **General** | **No** | **Yes** | **Dermatologic** | **No** | **Yes** | **Eyes** | **No** | **Yes** |
|---|---|---|---|---|---|---|---|---|
| **Fevers:** | ☐ | ☐ | **Skin rash:** | ☐ | ☐ | **Blurred Vision**: | ☐ | ☐ |
| **Chills:** | ☐ | ☐ | **Boils:** | ☐ | ☐ | **Double Vision:** | ☐ | ☐ |
| **Headache**: | ☐ | ☐ | **Itching:** | ☐ | ☐ | **Pain:** | ☐ | ☐ |

| **Musculoskeletal** | **No** | **Yes** | **Allergic/Immunologic** | **No** | **Yes** | **Ear/Nose/Throat** | **No** | **Yes** |
|---|---|---|---|---|---|---|---|---|
| **Joint Pain:** | ☐ | ☐ | **Hay Fever:** | ☐ | ☐ | **Ear Infection**: | ☐ | ☐ |
| **Neck Pain:** | ☐ | ☐ | **Recurrent Infections:** | ☐ | ☐ | **Sore Throat:** | ☐ | ☐ |
| **Back Pain**: | ☐ | ☐ | **Decreased Immune:** | ☐ | ☐ | **Sinus Infection:** | ☐ | ☐ |

| **Neurologic** | **No** | **Yes** | **Endocrine** | **No** | **Yes** | **Respiratory** | **No** | **Yes** |
|---|---|---|---|---|---|---|---|---|
| **Tremors:** | ☐ | ☐ | **Excessive thirst:** | ☐ | ☐ | **Wheezing**: | ☐ | ☐ |
| **Dizziness:** | ☐ | ☐ | **Too hot / cold:** | ☐ | ☐ | **Coughing:** | ☐ | ☐ |
| **Numbness / tingling:** | ☐ | ☐ | **Tired:** | ☐ | ☐ | **Shortness of breath** | ☐ | ☐ |

| **Gastrointestinal** | **No** | **Yes** | **Hematologic** | **No** | **Yes** | **Cardiovascular** | **No** | **Yes** |
|---|---|---|---|---|---|---|---|---|
| **Abdominal Pain:** | ☐ | ☐ | **Excessive bleeding:** | ☐ | ☐ | **Chest pain**: | ☐ | ☐ |
| **Nausea / vomiting:** | ☐ | ☐ | **Blood clots:** | ☐ | ☐ | **Shortness of breath:** | ☐ | ☐ |
| **Heartburn / indigestion:** | ☐ | ☐ | **Anemia:** | ☐ | ☐ | **Palpitations:** | ☐ | ☐ |

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## Review of Systems (Continued):

| **Psychologic** | **No** | **Yes** |
|---|---|---|
| **Depression:** | ☐ | ☐ |
| **Anxiety:** | ☐ | ☐ |
| **Difficulty sleeping**: | ☐ | ☐ |
| **Obsessive / compulsive:** | ☐ | ☐ |

## FOR WOMEN

The date of last menstrual period: _____

Number of children: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ 5 ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

Mode of delivery: _____

Mode of delivery: _____

Mode of delivery: _____

Mode of delivery: _____

Mode of delivery: _____

Mode of delivery: _____

**Patients Signature:** _____ **Date:** _____