

**NEW PATIENT HISTORY FORM** **TODAY'S DATE:**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Primary Care Physician:** \_\_\_\_\_

**Referring Urologist:** \_\_\_\_\_ **Cardiologist:** \_\_\_\_\_

**Chief Complaint:** Describe your problem:

\_\_\_\_\_

\_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

**Location of problem**  
 Abdomen Back/Kidney Bladder Genitalia Urine  
 Infertility  
 Other \_\_\_\_\_

**When did you first notice the problem?**  
 2 days ago      2 weeks ago      1 month ago

Other \_\_\_\_\_

**Do you have pain?**  Yes  No (if yes, please circle)  
 Dull      Sharp      Comes and goes      Always there

Other \_\_\_\_\_

**On a scale of 1-10, with 10 being the most severe,  
 Circle the number that best describes the pain:**  
 1 2 3 4 5 6 7 8 9 10

**Does anything help or make the problem worse?**  
 Moving around    Lifting/Straining    Eating/Drinking  
 Other \_\_\_\_\_

**How long does the pain last?**  
 30 minutes to 1 hour    1-3 hours    Always there  
 Other \_\_\_\_\_

**Is there anything else occurring at the same time?**  
 Yes  No (if yes, please circle)  
 Nausea/Vomiting      Fever/Chills      Diarrhea

Other \_\_\_\_\_  
**Does the problem interfere with your normal functions?**  
 Yes  No (If yes, please explain)  
 \_\_\_\_\_

**PAST MEDICAL HISTORY**

**List all past or present medical problems:**

**List any medications, herbs or supplements you take:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List any past surgeries:** \_\_\_\_\_ **Year** \_\_\_\_\_ **Do you have any allergies?**  Yes  No (If YES- Explain)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_

## Social History

**Occupation** \_\_\_\_\_  
**Retired**  Yes  No

**Do you currently use tobacco products:**  Yes  No  
Cigar \_\_\_\_\_  
If yes, How much? \_\_\_\_\_ How long? \_\_\_\_\_

**Have you quit using tobacco products in the last 12 months?**  Yes  No

**If you have used tobacco products in the past:**  
How many packs per day? \_\_\_\_\_ For how long? \_\_\_\_\_

**Do you drink:**  Yes  No  
If yes, type of alcohol & how much? \_\_\_\_\_

**Marital Status:**  Single  Married  Separated  Divorced  
**Children**  Yes How many? \_\_\_\_\_  No

### List all medical problems in your immediate family:

**Please check YES or NO**

Family history of prostate cancer  Yes  No

Family history of other cancer  Yes  No

If yes, please describe \_\_\_\_\_

Family history of kidney stones  Yes  No

Other Family history: \_\_\_\_\_

**Are you on a Special diet?**  Yes  No

If yes, explain \_\_\_\_\_

**REVIEW OF SYSTEMS****Do you now or have you had any problems related to the following systems?****Please check box  YES or  NO****You may explain any positive answers in the space provided.****Constitutional Symptoms**

- Fever  Yes  No  
 Chills  Yes  No  
 Feeling Tired/Sluggish  Yes  No  
 Weight Gain or Weight loss  Yes  No  
 If yes, how many \_\_\_\_\_ lbs.

**Eyes**

- Eyesight problems  Yes  No  
 Dry eyes  Yes  No  
 Other \_\_\_\_\_

**Ear/Nose/Throat/Mouth**

- Earache  Yes  No  
 Sore throat  Yes  No  
 Sinus problems  Yes  No  
 Other \_\_\_\_\_

**Cardiovascular**

- Chest pain  Yes  No  
 High blood pressure  Yes  No  
 Palpitations  Yes  No  
 Other \_\_\_\_\_

**Respiratory**

- Shortness of breath  Yes  No  
 Wheezing  Yes  No  
 Frequent cough  Yes  No  
 Other \_\_\_\_\_

**Gastrointestinal**

- Abdominal pain  Yes  No  
 Nausea/vomiting  Yes  No  
 Heartburn/Indigestion  Yes  No  
 Constipation  Yes  No  
 Diarrhea  Yes  No

**Musculoskeletal**

- Joint pain  Yes  No  
 Joint Swelling  Yes  No  
 Limb swelling  Yes  No  
 Other \_\_\_\_\_

**Skin (Integumentary)**

- Skin lesions  Yes  No  
 Itching  Yes  No  
 Skin Wound  Yes  No  
 Other \_\_\_\_\_

**Neurological**

- Dizziness  Yes  No  
 Limb weakness  Yes  No  
 Difficulty walking  Yes  No  
 Other \_\_\_\_\_

**Endocrine**

- Muscle weakness  Yes  No  
 Hot Flashes  Yes  No  
 Feelings of weakness  Yes  No  
 Other \_\_\_\_\_

**Hematological/Lymphatic**

- Swollen glands  Yes  No  
 Easy bruising  Yes  No  
 Easy bleeding  Yes  No  
 Other \_\_\_\_\_  Yes  No

**Sexual History**

- Painful intercourse  
 Loss of interest  
 Men - poor quality erections  
 Men - no erections  
 Interested in treatment/evaluation of sexual problem

**Genital Infections**

- Genital bacterial infection  
 Genital yeast infection  
 Sexually Transmitted Disease (STD)  
 Other \_\_\_\_\_

**Genitourinary**

- Seen by a urologist before  
 (Name) \_\_\_\_\_  
 Urine infections (bladder/kidney)  
 Painful urination  
 Blood in urine that you can see  
 Told you have blood in urine on a urine test  
 Discharge from urine canal  
 History of kidney stones  
 Stones in urine  
 Urine retention  
 Wake up at night to urinate.  
 If yes, how many times \_\_\_\_\_  
 Strong urge to urinate  
 Strong urge to urinate causing leak of urine  
 Bladder pressure  
 Frequent urination  
 If yes, how often daytime \_\_\_\_\_  
 Strain or push to urinate  
 Wait a long time to urinate  
 Slow urine stream  
 Interrupted urine stream  
 Bladder fullness after urinating

**Incontinence**

- Leak urine  
 Leak urine with cough/strain/laughing  
 Dribbling of urine  
 Other \_\_\_\_\_

**Women Only**

- Date of last menstrual period \_\_\_\_\_  
 Abnormal menstrual period  
 If yes, explain \_\_\_\_\_  
 It is possible that I am pregnant  
 Presently in menopause  
 Other \_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_

<b>AUA SYMPTOM SCORE</b>	Not at all <b>0</b>	Less than 1 time in 5 <b>1</b>	Less than half the time <b>2</b>	About half the time <b>3</b>	More than half the time <b>4</b>	Almost always <b>5</b>
Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?						
Over the past month, how often had you had to urinate again less than two hours after you finished urinating?						
Over the past month, how often have you found it difficult to postpone urination?						
Over the past month, how often have you had a weak urinary stream?						
Over the past month, how often have you had to push or strain to begin urination?						
Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?						

<b>Quality of Life Related to Urinary Symptoms</b>	None <b>0</b>	Only a little <b>1</b>	Some <b>2</b>	A lot <b>3</b>
Over the past month, how much physical discomfort did you any urinary problems cause you?				
Over the past month, how much did you worry about your health because of urinary problems?				

	None <b>0</b>	Only a little <b>1</b>	Some <b>2</b>	A lot <b>3</b>
Overall, how bothersome has any trouble with urination been during the past month?				

Do you have a History of Bleeding?  Yes  No, If yes Please Explain: \_\_\_\_\_

\_\_\_\_\_