UROLOGIC HISTORY FORM

FIVE VALLEYS UROLOGY

Today's Date:_____

Name:_____ Date of Birth:_____/_____/_____

Please Circle Race:
African American Asian
American Indian Black
Alaskan Native Hispanic
Native Hawaiian Other

Age:_____ Weight:_____ Height:_____ Gender:_____

Primary Doctor:_____ Referring Doctor:_____

Have you been seen by us in the past? Yes No If yes, when?_____ By whom?_____

Occupation:_____ Do you have an Advanced Care Directive? Yes No (please bring copy)

MEDICATIONS/ALLERGIES/IMMUNIZATIONS LIST

ALLERGIES: None Codeine IVP Dye Latex Mycins Penicillin Sulfa Cipro/Levaquin

OTHER ALLERGIES:_____

PHARMACY NAME & ADDRESS:_____

PHARMACY PHONE & FAX:_____ **MAIL ORDER?** Yes No

BLOOD THINNERS: Aspirin Plavix Warfarin Coumadin Ibuprofen Aleve Motrin Celebrex Other:_____

IMMUNIZATIONS: Influenza Immunization? N Y date _____ Pneumococcal Vaccination? N Y date_____

Medications: Please list all prescription & OTC medications and supplements	**Dose**	**How Often**

MEDICAL HISTORY

Check any past & ongoing medical problems

- □ Acid Reflux
- □ Anemia
- □ Angina
- □ Arthritis
- □ Asthma
- □ Cancer: type_____
- □ Chronic UTIs
- □ Congestive Heart Failure
- □ COPD
- □ Coronary Artery Disease
- □ Chron's Disease
- □ Dementia
- □ Depression
- □ Diabetes: # of years___
- □ Diverticulitis
- □ Enlarged Prostate
- □ Glaucoma
- □ Gout
- □ Heart Attack
- □ Hepatitis C
- □ High Blood Pressure
- □ High Cholesterol
- □ HIV
- □ IBS
- □ Kidney Disease
- □ Kidney Stones
- □ Liver Disease
- □ Lupus
- □ Migraines
- □ Multiple Sclerosis
- □ Neurologic
- □ Osteoarthritis
- □ Osteoporosis
- □ Parkinson's
- □ Peptic Ulcer
- □ Peripheral Vasc. Disease
- □ Rheumatoid Arthritis
- □ Seizure Disorder
- □ Stroke
- □ Thyroid Disease

Other (please explain)_____ Hearing loss? Yes No Hearing Aids? Yes No

Over ➡

Check if "C" for Current or "P" for Past to any urological problems below

			Gender specific – female			Gender specific – male		
□	Blood in your urine	C P	□	Pregnant	C P	□	Undescended Testicles	C P
□	Urinary Tract Infection	C P	□	Trying to become pregnant	C P	□	Curvature of the penis	C P
□	Loss of urine when you cough, sneeze, or strain	C P	□	Cysts	C P	□	Varicocele	C P
□	Kidney or Bladder Stones	C P	□	Menstrual pain	C P	□	Epididymitis	C P
□	Bedwetting or daytime wetting of clothes	C P	□	Organ prolapse	C P	□	Problems with sex drive	C P
□	Skin problems in genital or groin area	C P	□	Endometrioses	C P	□	Problems with ejaculation	C P
□	Pain with sexual intercourse	C P	□	Vaginal dryness	C P	□	Problems getting or keeping erections	C P
□	History of sexually transmitted disease	C P						
□	Bowel Incontinence	C P						

SURGICAL HISTORY

Check any past surgical history

		date		Gender specific - female	date		Gender specific - male	date
□	Appendectomy	_____	□	Bladder Suspension	_____	□	Prostate Surgery	_____
□	Back Surgery	_____	□	Breast Biopsy	_____	□	Penile Prosthesis	_____
□	Heart Bypass	_____	□	C-Section	_____	□	Prostate Biopsy	_____
□	Colon Surgery	_____	□	Hysterectomy	_____	□	Scrotal Area Surgery	_____
□	Heart Stent	_____	□	Mastectomy R / L	_____	□	Testicle Removal	_____
□	Gallbladder	_____	□	Pubovaginal Sling	_____	□	Varicocele Surgery	_____
□	Gastric Bypass	_____	□	Tubal Ligation	_____	□	Vasectomy	_____
□	Hernia repair	_____	□	Vaginal Delivery	_____	□	Other:_____	_____
□	Hip Replacement R / L		□	Kidney Stones	_____	□	Pacemaker	_____
□	Kidney Removal R / L		□	Knee Replacement	_____	□	Tonsillectomy	_____

Other:_____

FAMILY HISTORY

Check any family history of illness

	Adopted? Y N	Father	Mother	Brother	Sister	Grandparent	Son	Daughter	Runs in Family
□	Diabetes								
□	Enlarged Prostate								
□	High Blood Pressure								
□	Kidney Stones								
□	Kidney Failure								
□	Prostate Cancer								
□	Stroke								
□	Urinary Tract Infections								
□	Cancer: Other_____								

SOCIAL HISTORY

MARITAL STATUS: S M D W Children? N Y # of sons:_____ # of daughters:_____

TOBACCO USE (please circle):Current Former Never Passive Smoke Exposure If quit, year:_____

If yes, Type:_____Have you tried to quit? N Y

ALCOHOL: Do you drink? N Y If yes, type_____ frequency_____ amount_____ last drink_____

If no, former drinker? N Y Have you ever undergone alcohol abuse treatment? N Y

CAFFEINE: N Y If yes, type:_____ Amount of caffeine per day:_____

DRUGS: Do you use drugs? N Y If yes, what kind and how often?_____ Have you been treated for drug abuse?_____

FAMILY: Mother Living? N Y If no, list cause of death & age_____ How many brothers do you have?

Father Living? N Y If no, list cause of death & age_____ How many sisters do you have?

CHIEF COMPLAINT & PRESENT ILLNESS

What is the main reason for your visit today?_____

Location of the problem

Abdomen Back Leg Flank

Pelvis Rectum Bladder Genitalia

Other_____

On a Scale of 1-10, with 10 being the most severe, which number best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other_____

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other_____

How long does the problem last?

30 minutes 1 hour It is always there

Other_____

Is anything else occurring at the same time? Yes No

(If yes, explain)_____

Do you have Nausea Rash Headaches Other?_____

Is the problem constant or variable?

Constant Variable Dull then Sharp Very sharp then leaves

Other_____

Does the problem interfere with your normal functions?

YES NO

Explain_____

What testing have you had to evaluate your urological problem? (Please circle)

X-Ray
CT Scan
MRI
IVP
Blood tests
Ultrasound
Nuclear bone scan
Nuclear renal scan
Urine Specimen
Cystoscopy
Urodynamic Testing
Other:_____
Unsure

Where were tests performed?_____

Urinary Questionnaire

Do you leak urine? Yes No If yes, is your leakage associated with the urge to urinate? Yes No

If yes, do you wear protective pads / protective liners / diapers Yes No #pads/day_____

Does your urine smell? Yes No Is your urine discolored? Yes No

Sexual Health Questionnaire

Are you satisfied with your sexual life? Yes No Do you have decreased libido/desire? Yes No

(Men only) Have you tried any medications for erectile dysfunction? Yes No If yes, which?_____

(Women only) Have you tried any treatments for vaginal tissue rejuvenation? Yes No If yes, which?_____

Over ➞

AUA SYMPTOM SCORE (AUASS)

Place patient label here

TODAY'S DATE:_____

(Circle One Number on Each Line)	Not at All	Less Than 1 Time in 5	LessThan Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 or More Times
Over the past month, how many times per night 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?	0	1	2	3	4	5

Add the score for each number above and write the total in the space to the right. **TOTAL:** _____

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

Review of Systems

FIVE VALLEYS UROLOGY

Today's Date___/___/_____

Please check any problems you have or have had in the past month

Constitutional Symptoms — Explain any Current
- Fever ☐
- Chills ☐
- Headaches ☐
- Other ☐

Eyes
- Blurred Vision ☐
- Double Vision ☐
- Pain ☐
- Other ☐

Ear/Nose/Throat/Mouth
- Ear Infection ☐
- Sore Throat ☐
- Sinus Problems ☐
- Other ☐

Cardiovascular
- Chest Pain ☐
- Varicose Veins ☐
- High Blood Pressure ☐
- Other ☐

Respiratory
- Wheezing ☐
- Frequent Cough ☐
- Shortness of Breath ☐
- Other ☐

Gastrointestinal
- Abdomen Pain ☐
- Nausea/Vomiting ☐
- Indigestion/Heartburn ☐
- Other ☐

Genitourinary
- Urine Retention ☐
- Painful Urination ☐
- Urinary Frequency ☐
- Other ☐

Reproductive - Female
- Breast Lumps/Pain ☐
- Vaginal Discharge ☐
- Other_____ ☐

Integumentary — Explain any Current
- Skin Rash ☐
- Boils ☐
- Persistent Itch ☐
- Other ☐

Neurological
- Tremors ☐
- Dizzy Spells ☐
- Numbness/Tingling ☐
- Other ☐

Musculoskeletal
- Joint Pain ☐
- Neck Pain ☐
- Back Pain ☐
- Other ☐

Endocrine
- Excessive Thirst ☐
- Too hot/cold ☐
- Tired/Sluggish ☐
- Other ☐

Psychologic

Are you satisfied with your life? Yes No

Explain if no_____

Do you feel depressed? Yes No

Explain if yes_____

Hematological/Lymphatic
- Swollen Glands ☐
- Blood Clotting ☐
- Other ☐

Allergic/Immunologic
- Hay Fever ☐
- Drug Allergies ☐
- Other ☐
- Other ☐

Reproductive - Male
- Penile Discharge ☐
- Erectile Dysfunction ☐
- Other_____ ☐

Physician Use Only:

Physician:_____ Date:_____

Level of Service
#
0- Lvl 1 or 2
2- Lvl 3
9
1 Lvl 4 or 5
0
+