

UROLOGIC HISTORY FORM



Today's Date: _____

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

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

Primary Doctor: _____ Referring Doctor: _____

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

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

SURGICAL HISTORY

Check any past surgical history

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

Other: _____

FAMILY HISTORY

Check any family history of illness

	Adopted? Y N	Father	Mother	Brother	Sister	Grandparent	Son	Daughter	Runs in Family
<input type="checkbox"/>	Diabetes								
<input type="checkbox"/>	Enlarged Prostate								
<input type="checkbox"/>	High Blood Pressure								
<input type="checkbox"/>	Kidney Stones								
<input type="checkbox"/>	Kidney Failure								
<input type="checkbox"/>	Prostate Cancer								
<input type="checkbox"/>	Stroke								
<input type="checkbox"/>	Urinary Tract Infections								
<input type="checkbox"/>	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	Less Than 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

- Fever
- Chills
- Headaches
- Other

Explain any Current

Integumentary

- Skin Rash
- Boils
- Persistent Itch
- Other

Explain any Current

Eyes

- Blurred Vision
- Double Vision
- Pain
- Other

Neurological

- Tremors
- Dizzy Spells
- Numbness/Tingling
- Other

Ear/Nose/Throat/Mouth

- Ear Infection
- Sore Throat
- Sinus Problems
- Other

Musculoskeletal

- Joint Pain
- Neck Pain
- Back Pain
- Other

Cardiovascular

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

Endocrine

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

Respiratory

- Wheezing
- Frequent Cough
- Shortness of Breath
- Other

Psychologic

Are you satisfied with your life? Yes No
 Explain if no _____
 Do you feel depressed? Yes No
 Explain if yes _____

Gastrointestinal

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

Hematological/Lymphatic

- Swollen Glands
- Blood Clotting
- Other

Genitourinary

- Urine Retention
- Painful Urination
- Urinary Frequency
- Other

Allergic/Immunologic

- Hay Fever
- Drug Allergies
- Other
- Other

Reproductive - Female

- Breast Lumps/Pain
- Vaginal Discharge
- Other _____

Reproductive - Male

- Penile Discharge
- Erectile Dysfunction
- Other _____

Physician Use Only: Physician: _____	Level of Service # 0- Lvl 1 or 2 2- Lvl 3 9 1 Lvl 4 or 5 0 +
Date: _____	