

VIEWONT UROLOGY CLINIC, P.A.

PATIENT NAME: _____ **DATE:** _____ **CHART #** _____

Requesting Physician: _____ **General Physician:** _____ **Time:** _____

PMH: Have you ever had or been treated for:

Sugar Diabetes: no yes when was it diagnosed? _____ Insulin? yes no
 Heart Attack: no yes when? _____
 Other heart trouble: no yes what kind? _____
 Stroke: no yes when? _____
 High blood pressure: no yes when was it diagnosed? _____
 Cancer: no yes what kind(s)? _____

Any other medical problems: _____

Women Only: How many pregnancies? _____ How many babies born? _____ Prior hysterectomy? yes no
 Last menstrual period: _____ Are you using birth control? no yes Type: _____

PSH: What operations have you had and when?
 None

FH: Does or did anyone in your family other than you have:

Relation to you:

Kidney stones yes no _____
 Kidney failure yes no _____
 Prostate problems yes no _____
 Prostate cancer yes no _____
 Other cancers: _____
 Other medical problems: _____

SH: Marital status: _____ # of children: _____ # Sons: _____ Occupation: _____
 Do you **smoke/use tobacco**? yes no Have you ever? yes no **IF SO:** How many packs per day? _____
 And how many years? _____ If you have quit smoking (congratulations!), when did you quit? _____
 Do you drink **beer or alcohol**? none small amount moderate large amount
 How much **caffeine** do you take daily? none small amount moderate large amount

SYSTEM REVIEW

Please answer the following questions regarding any recent symptoms that you may be experiencing:

Constitutional Symptoms

Fever yes no
 Chills yes no

Head/Eyes/Ears/Nose/Throat

Headaches yes no
 Double vision yes no
 Eye pain yes no
 Ear infections yes no
 Nasal congestion yes no
 Sore throats yes no

Respiratory

Asthma yes no
 Frequent cough yes no
 Wheezing yes no

Cardiovascular

Chest pain yes no
 Shortness of breath yes no
 Swelling of feet yes no

Gastrointestinal

Nausea yes no
 Vomiting yes no
 Constipation yes no
 Diarrhea yes no
 Decrease in appetite yes no
 Weight loss yes no

Genitourinary

Burning with voiding yes no
 Blood in the urine yes no

Reproductive

Decreased sex drive yes no
 Difficulty with intercourse yes no

Metabolic/Endocrine

Cold intolerance yes no
 Heat intolerance yes no
 Excessive thirst yes no

Neurological

Dizzy spells yes no
 Tremors yes no
 Numbness or tingling yes no

Psychological

Depression yes no
 Excessive anxiety yes no

Skin

Skin rashes yes no
 Persistent itching yes no

Musculoskeletal

Back pain yes no
 Bone/Joint Symptoms yes no

Hematological

Easy bruising yes no
 Easy bleeding yes no

List any other symptoms that bother you

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PATIENT NAME: _____ DATE: _____ CHART # _____

CC: Describe the MAIN PROBLEM(S) for which you came today or were sent here today?

How long has this been a problem? _____

Did it develop suddenly or gradually ?

Has it been constant variable or intermittent ?

Do you have any of the following associated symptoms?

Pain or burning with urination? yes no

Marked urgency to void? yes no

Frequency of urination? yes no

Incontinence? yes no explain _____

Have you ever had any of the following?

Blood in the urine? yes no

Kidney stones? yes no

Infections of the kidney bladder prostate or UTIs ?

Problems with erections or sexual function? yes no

Are you allergic to IV dyes, shellfish or iodine? no yes (explain) _____

Do you take Aspirin, Aleve, Motrin, Ibuprofen, or other anti-inflammatory or pain medications? no yes (explain) _____

ALLERGIES: None

Are you allergic to any medications?

What type of reaction have they caused?

MEDICATIONS: None

Name of medicine

Dosage

