Today's Date:

New Patient to Urology
--Male Patient--

Patient Label

*What is your WEIGHT? *What is your HEIGHT?

BP
HR
RR

Pharmacy_____ Location_____

Did a Physician refer you here? If yes, please print their name and address below:

What is the reason for your visit, today?

--Medical History--

Problem or Symptom	Yes	No	Physician Comments Only
Lately, have you unintentionally lost or gained weight?			
Lately, have you had any fever, chills, or night sweats?			
Do you have nausea, vomiting, or diarrhea?			
Do you have skin rashes, boils, or a persistent itch?			
Have you had any changes in your vision?			
Do you have bloody noses, ear infections, or sinus problems?			
Have you had chest pain?			
Do you have shortness in breath? Wheezing?			
Do you have seizures or black out spells?			
Do you have joint, back, or muscle pain?			
Recently, have you been injured in a fall or accident?			
Do you experience problems with depression? Anxiety?			
Do you have abdominal or flank pain?			
Have you ever had kidney stones?			
Have you ever had blood in urine?			
Have you ever had kidney or urinary tract infections?			
Do you have pain or burning while urinating?			
Do you have frequent urination?			
Do you have a weak urine stream?			
Does your urine stream start and stop?			
Do you have incontinence (leakage) of urine?			
Do you have problems with your erections?			
Do you take medications to achieve your erections?			
Are you having problems with your sexual drive?			
Have you ever had any testicular pain ?			
Have you experienced blood in your semen?			

Please list any medical illnesses you have had (High blood pressure, Diabetes, Heart Attack, Stroke, etc):

Please list any Surgeries:	Please list approximate dates:

Please list your current medications:	Are you allergic to any medications? Please list:

--Social History--

What is/was your occupation? _____

What is your marital status? _____ Number of Children? _____

How much alcohol do you consume weekly? _____

Do you smoke? _____ How many packs per day? _____ Did you smoke in the past?____

Any other drug use? _____

Is there a family history of (Please circle if yes)

Heart Disease	Urinary Stones	Bladder Cancer
Stroke	Kidney Disease	Other Specific Disease:
Diabetes	Prostate Cancer	