Name: ______________________ Date of Birth: ______________

Physician Partners Urology

PCP: ______________________ Referred by: ______________

Today's Concerns

Please describe your reason for today's visit ______________________________

How long has this been going on? ______________________________

How severe is the problem? ☐ Mild ☐ Moderate ☐ Severe ☐ Other ______________

How often do your symptoms occur? ☐ Constantly ☐ Daily ☐ Weekly ☐ Monthly ☐ Randomly

Does anything special make your condition worse? ☐ Yes ☐ No please describe: ______________

____

Does anything in particular help with your condition? ☐ Yes ☐ No please describe: ______________

____

Allergies/Medications

List all medication/dosage	List current Medication ALLERGIES/reaction
______________	______________
______________	______________
______________	______________
______________	______________
______________	______________
______________	______________

List previous surgeries with dates: ______________________________

____

____

____

Are you allergic to Latex? ☐ Yes ☐ No Reaction: ______________________

Do you take daily aspirin? ☐ Yes ☐ No Do you Smoke? ☐ Yes ☐ No # per day ______________

Do you drink alcohol? ☐ Yes ☐ No How often? ______________

Are you married? ☐ Yes ☐ No Do you have children? ☐ Yes ☐ No – If Yes, # Male ______ Female ______

Are your parents living? ☐ Yes ☐ No How many siblings do you have? Brothers ______ Sisters ______

Family history of: (please circle) Prostate Cancer? Breast Cancer? Ovarian cancer? Pancreatic cancer?

If so Whom? ______________________________

OVER→

Name: ______________________ Date of Birth: ______________________

Your Medical History

Have you had or are you being treated for any of the following medical problems? (Please check all that apply)

Blood Problems
- ☐ Anemia
- ☐ Blood Clots (DVT/Embolism)
- ☐ Clotting disorder
- ☐ Bleeding disorder
- ☐ HIV Positive
- ☐ Sickle Cell

Cardiac/Vascular
- ☐ Chest pain (angina)
- ☐ Heart attack or arrhythmia
- ☐ Atrial fibrillation
- ☐ Heart failure
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Blood vessel problems in legs
- ☐ Malignant hyperthermia

Cancer – List type/location
- ☐ ______________
- ☐ ______________
- ☐ ______________

Female specific
- ☐ Abnormal pap smears

Endocrine
- ☐ Diabetes
- ☐ Hyperthyroid disease
- ☐ Hypothyroid disease
- ☐ Adrenal disease

Gastrointestinal
- ☐ Anal/Rectal trauma/injury
- ☐ Colorectal polyps
- ☐ Crohn's disease
- ☐ Gluten sensitivity (celiac)
- ☐ Irritable bowel syndrome
- ☐ Leakage of stool
- ☐ Ulcerative colitis

Infection
- ☐ Hepatitis type:
- ☐ MRSA
- ☐ VRE

Kidney/Urinary
- ☐ Leakage of urine
- ☐ Poor kidney function
- ☐ Renal failure

Musculoskeletal
- ☐ Arthritis
- ☐ Back problems
- ☐ Gout
- ☐ Pelvic fracture

Neurological
- ☐ Multiple sclerosis
- ☐ Neuropathy
- ☐ Seizures
- ☐ Spinal cord injury
- ☐ Stroke
- ☐ TIA

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Sleep apnea
- ☐ Other ______________

Male specific
- ☐ Erectile dysfunction
- ☐ Enlarged prostate

Current Review of Systems

Are you experiencing any of these symptoms? *Please check all that apply.*

Constitutional

Weight loss ☐ Yes ☐ No
Fatigue ☐ Yes ☐ No

HEENT

Dry mouth ☐ Yes ☐ No
Dry eyes ☐ Yes ☐ No

Cardiovascular

Chest pain ☐ Yes ☐ No
Irregular heartbeat (palpitations) ☐ Yes ☐ No

Pulmonary

Shortness of breath ☐ Yes ☐ No
Cough ☐ Yes ☐ No

Gastrointestinal

Abdominal pain ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Nausea/Vomiting ☐ Yes ☐ No

Hematologic

Easy bleeding ☐ Yes ☐ No

Bladder

Blood in urine (hematuria) ☐ Yes ☐ No
Frequency of urination ☐ Yes ☐ No
Pain with urination (dysuria) ☐ Yes ☐ No

Neurologic

Numbness/tingling ☐ Yes ☐ No

Mental Health

Anxiety ☐ Yes ☐ No
Depression ☐ Yes ☐ No

Musculoskeletal

Back pain ☐ Yes ☐ No
Joint pain ☐ Yes ☐ No

OVER →