POPLAR BLUFF UROLOGY
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Please fill both sides of the two sheets as completely as possible
If you have any questions or need any clarification, please ask the nurse

Name:________________________________**Age**:_____yrs **Sex**: FEMALE

Race: _______**Marital Status**:_______________**Occupation**________________

Physician requesting Consult:______________________**Today's Date:**________

What are your chief complaints:

1___________________________________For how long____________

Severity (0-10) ___________What brought it on?________________

Anything makes it better?____________, worse?________________

2___________________________________ For how long ___________

Severity (0-10) ___________What brought it on?________________

Anything makes it better?____________, worse?________________

3___________________________________ For how long ___________

Urologic History: *(Please circle one)*

1. Do you have any difficulty voiding? Yes / No

If yes:Hesitancy____, Straining____, Incomplete emptying_____

2. Do you have any symptoms of overactive bladder? Yes / No

If yes: Daytime frequency every___hour(s)

Night time ____times/night, urgency: yes/no

3. Do you leak urine? Yes / No

4. Do you have a Bladder/Kidney infection? Yes / No

5. Do you have any pain? Yes / No

6. Do you have a lack of desire for sex Yes /No

7. Is intercourse painful? Yes / No

8. Do you have blood in the urine? Yes / No

If yes: initial / terminal / total; gross / micro; painful / painless

8. Do you *have / ever had* kidney stones Yes / No

9. Do you have any genital lesions / STDs Yes / No

If yes, describe_________________________________

12. Any change in bowel habits? Constipation? Fecal leakage? Yes / No

10. Do you feel a bulge in your vagina? Yes / No

Reviewed

____

Doctor's Initials

PATIENT:____ **DOB:**___________________

Review of Systems: Do you now or have you had problems related to the following systems. Circle yes or no. If yes please explain in the space provided.

Constitutional
- Fever Y N
- Chills Y N
- Headaches Y N
- Other___________________________

Eyes
- Blurred vision Y N
- Double vision Y N
- Pain Y N
- Other___________________________

Ear/ Nose/ Throat/ Mouth
- Ear infection Y N
- Sore throat Y N
- Sinus problems Y N
- Hearing problems Y N
- Other___________________________

Cardiovascular
- Chest Pain Y N
- High Blood Pressure Y N
- Varicose Veins Y N
- Heart Disease Y N
- Heart Attack Y N
- Other___________________________

Neurological
- Tremors Y N
- Dizzy Spells Y N
- Numbness/Tingling Y N
- Stroke Y N
- Other___________________________

Endocrine
- Excessive thirst Y N
- Too hot/cold Y N
- Tired/sluggish Y N
- Other___________________________

Infection
- Mumps Y N
- Tuberculosis Y N
- AIDS/ HIV Y N
- Other___________________________

Integumentary/Skin
- Skin Rash Y N
- Boils Y N
- Persistent itch Y N
- Other________________________________

Allergy/Immunologic
- Hay Fever Y N
- Allergies Y N
- AutoImmune diseases Y N
- Other________________________________

Respiratory
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Hoarseness Y N
- Other________________________________

Gastrointestinal
- Abdominal Pain Y N
- Nausea/vomiting Y N
- Indigestion/Heartburn Y N
- Diarrhoea Y N
- Constipation Y N
- Other________________________________

MusculoSkeletal
- Joint Pain Y N
- Neck Pain Y N
- Back Pain Y N
- Muscle weakness Y N
- Other_______________________________

Hematology/ Oncology
- Swollen Glands Y N
- Bleeding Disorders Y N
- Cancer Y N
- Other_______________________________

Psychologic
- Depression Y N
- Suicidal Y N
- Bipolar Y N
- Other_______________________________

Nurses Notes:

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Nurse's Signature__________________________________Date__________________

Reviewed

____

Doctor's Initials

PATIENT:____ DOB:____________________

Medications: Please list all the medications you are on, *including over the counter and herbal medications.* None__________

Drug	Dosage MgsXtimes/day	Reason/condition for which you are taking it?

Pharmacy:____________________________________ **Phone Number:**_______________

Drug Allergies: ______None

Name of drug	Reaction		Name of drug	Reaction

Surgical History: ______None

Year	Operation	Complications

Have you had a **blood transfusion?** Yes / No, If yes date(s)_______________
Reason_______________________

Any hospital admissions not listed above? _____None

Year	Reason	Complication

Reviewed
____
Doctor's Initials

Ob history: (Female patient only) *(Please circle one)*

1. Are you pregnant?____________Last menstrual period?__________
2. # of pregnancies_____, # of deliveries_____, # of miscarriages______
3. Type of delivery: Spontaneous vaginal/ Forceps/ Caesarian Section
4. Menopause Yes/ No. Year______

Personal History: *(Please circle one)*

1. Do you smoke? Yes / No If yes, # of pkts____# of yrs____
   Did you ever smoke? Yes/No If yes Quit when?__________
   Do you chew tobacco? Yes/No; if yes quantity ___________
2. Do you drink alcohol? Yes/ No If yes, amount_____# of yrs____
3. Do you use recreational drugs? Yes / No, If yes what__________
4. Any dietary excesses? Yes/No If yes what______________________

Family History: Do *your family members* suffer from

Genito-urinary **malignancies/cancers**: Yes / No

If yes, relationship and which kind:____________________________________

Kidney Stones: Yes / No

Condition	Family Y/N	Relation	Notes
Mental problems(name)			
Bleeding Disorders			
Thyroid disease			
Diabetes			
High Blood Pressure			
Asthma			
Kidney disease			
Kidney stone			
Bladder Cancer			
Prostate Cancer			
Other cancer (name)			
Stroke			
Heart Problems (name)			
Other (name)			
Other (name)			

Any additional information:____

The above information is true and accurate.

Patient/Guardian's Signature______________________________Dated:________________

I have reviewed the above information with the patient

Doctors Signature______________________________________Dated________________

Level of History	Prob Focussed: CC + 1 HPI	Exp. Prob. Focussed CC + 1 HPI + 1 ROS	Detailed: CC+4 HPI+2 ROS+1PFSH	Comprehensive: CC+4HPI+10ROS+3PFSH