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**: Male

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 Burning during urination: 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 erectile dysfunction / Impotence Yes / No

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

8.. Is intercourse painful? Yes / No

9. Does your penis curve when erect? Yes/No

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

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

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

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

If yes, describe_____

- Date of last PSA draw and level of PSA:_____

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:

_____

_____

_____

_____

_____

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

PATIENT:_____ **DOB:**_____

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

Prostate Cancer or other Genito-Urinary **Malignancy/Cancers:** Yes / No

If yes, relationship and type of cancer:_____

Kidney Stones: Yes / No

Condition	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