Patient Name ____ Date _____________________________

Reason for Your Visit

Chief Complaint

What is the main reason for your visit today? ____

Have you ever seen a Urologist before? ___Yes ___ No If yes, who and When? ________________________________

History of Present Illness:

When did you first notice the problem? Date: (MM/YY) ____

Is the problem continuous or does it come and go? ____

Does anything make your problem worse or better? ___ Yes ___ No Which? ___ Worse ___ Better

Review of Systems

Do you currently have any problems listed below: (Please Check One)

Constitutional Symptoms

Weight Loss ___ Yes ___ No
Fever ___ Yes ___ No
Chills ___ Yes ___ No
Other ___ Yes ___ No

Eyes

Blurred Vision ___ Yes ___ No
Eye Pain ___ Yes ___ No
Other ___ Yes ___ No

Cardiovascular

Chest Pain ___ Yes ___ No
Rapid Heartbeat ___ Yes ___ No
Other ___ Yes ___ No

Respiratory

Shortness of Breath ___ Yes ___ No
Frequent Cough ___ Yes ___ No
Other ___ Yes ___ No

Gastrointestinal

Constipation ___ Yes ___ No
Diarrhea ___ Yes ___ No
Abdominal Pain ___ Yes ___ No
Vomiting ___ Yes ___ No
Other ___ Yes ___ No

Genitourinary

Blood in Urine ___ Yes ___ No
Urinary Frequency ___ Yes ___ No
Burning on Urination ___ Yes ___ No
Urinary Leakage ___ Yes ___ No
Bedwetting ___ Yes ___ No
Difficulty with Intercourse ___ Yes ___ No
Other ___ Yes ___ No

Neurological

Tremors ___ Yes ___ No
Loss of Balance ___ Yes ___ No
Memory Loss ___ Yes ___ No
Other ___ Yes ___ No

Musculoskeletal

Joint Pain ___ Yes ___ No
Bone Pain ___ Yes ___ No
Back Pain ___ Yes ___ No
Other ___ Yes ___ No

Endocrine

Heat Intolerance ___ Yes ___ No
Cold Intolerance ___ Yes ___ No
Increased Thirst ___ Yes ___ No
Other ___ Yes ___ No

Hematologic

Easily Bruised ___ Yes ___ No
Swollen Lymph Nodes ___ Yes ___ No
Easy Bleeding ___ Yes ___ No
Other ___ Yes ___ No