ACADEMIC UROLOGY

PATIENT INTAKE FORM

Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____

Marital Status: Married Single Divorced Widow Separated Unknown

What is the main reason that you are seeing the doctor today?

Your Past Medical History: Please check all that apply

A) Medical Conditions

_____ Diabetes
_____ High Blood Pressure
_____ Heart Attack
_____ Stroke
_____ Pacemaker
_____ Bleeding Problems
_____ Cancer of _____
_____ Other _____
_____

B) Diseases of: (please explain)

_____ Heart (coronary artery disease, cardiomyopathy, etc. _____
_____ Lungs (asthma, emphysema, etc.) _____
_____ Liver _____
_____ Kidneys _____
_____ Nervous System (seizures, etc.) _____
_____ Immune System (AIDS, etc.) _____
_____ Other _____
_____

Do you require antibiotics for dental/medical procedures? Yes No
What drug? _____ Why? _____

Surgeries: Please note approximate date and hospital performed:

Family History: List your parents' ages & medical conditions if living. If parents are deceased, list ages and cause of death.
Father: _____
Mother: _____
Children? Yes No Number _____

Have you ever had a blood transfusion? _____

Cigarettes: (packs per day) _____
Yes Not Anymore Never Smoked

Alcoholic Beverages: (drinks per day) _____
Caffeinated beverages per day _____

ALLERGIES: (list all allergies to medications, anesthetics, contrast agents, etc…) _____
_____

Is there a family history of: Prostate Cancer Kidney Cancer Bladder Cancer Kidney Stones Diabetes

Heart Attack Stroke Cancer Bleeding Disorders

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REVIEW OF SYSTEMS

PATIENT NAME: _____ DATE: _____

Male Only — AUA Symptom Score: Circle one number in each line

Questions to be answered	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Over the past month, how often have you had to urinate less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. On a nightly basis, how many times do you typically get up to urinate?	0	1	2	3	4	5

Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Sum the seven circled numbers (AUA Symptom Score): **Scoring:** Mild 0-7 Moderate 8 - 19 Severe 20-35

Have you had a PSA? Y N

Result _____ Date: _____

Do you have trouble with?

Erections? Y N Do you want help with? Y N
Sex Drive? Y N Do you want help with? Y N

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REVIEW OF SYSTEMS (continued)

Patient Name: _____ Date: _____

Do you have any problems now or have you had any related to the following systems?
PLEASE CIRCLE YES OR NO

Constitutional Symptoms		
Fever	Yes	No
Chills	Yes	No
Weight Change	Yes	No
HEIGHT:		
WEIGHT:		

Eyes		
Glaucoma	Yes	No
Cataracts	Yes	No
Blurry Vision	Yes	No
Double Vision	Yes	No
Other		
COMMENTS:		

Cardiovascular		
Chest pain	Yes	No
Heart Attack	Yes	No
Irregular Heartbeat	Yes	No
Swelling in Ankles	Yes	No
High Blood Pressure	Yes	No
Angina	Yes	No
Congestive Heart Failure	Yes	No
Problem with Heart Valves	Yes	No
Rheumatic Fever	Yes	No
Other		
COMMENTS:		

Psychological		
Anxiety	Yes	No
Depression	Yes	No
Difficulty Sleeping	Yes	No
Other		
COMMENTS:		

Genitourinary		
Change in Stream	Yes	No
Nocturia (getting up at night)	Yes	No
Urinary frequency >8 times/day	Yes	No
Dysuria (Burning with urination)	Yes	No
Blood in Urine	Yes	No
Urinary tract infection	Yes	No
Kidney Stones	Yes	No
Urinary Leakage	Yes	No
Other		
COMMENTS:		

Musculoskeletal		
Muscle weakness	Yes	No
Joint Pain (Swelling)	Yes	No
Arthritis	Yes	No
History of Orthopedic Surgery	Yes	No
Chronic Back Pain	Yes	No
Chronic Neck Pain	Yes	No
Other		
COMMENTS:		

Neurological		
Tremors	Yes	No
Dizzy Spells	Yes	No
Numbness/tingling	Yes	No
Stroke	Yes	No
Weakness	Yes	No
Difficulty walking	Yes	No
Loss of bowel control	Yes	No
Other		
COMMENTS:		

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REVIEW OF SYSTEMS (continued)

Patient Name _____ **Date**_____

Endocrine		
Excessive Thirst	Yes	No
Too Hot/Cold	Yes	No
Thyroid Condition	Yes	No
Diabetes	Yes	No
Other		
COMMENTS:		

Hematologic/Lymphatic		
Swollen Glands	Yes	No
Blood clotting problem	Yes	No
Easy Bleeding/Bruising	Yes	No
Anemia	Yes	No
Enlarged Lymph Nodes	Yes	No
Transfusion History	Yes	No
Immune Deficiency	Yes	No
Other		
COMMENTS:		

Respiratory		
Wheezing	Yes	No
Chronic Cough	Yes	No
Shortness of breath	Yes	No
Emphysema	Yes	No
Exposure to TB	Yes	No
Other		
COMMENTS:		

Gastrointestinal		
Abdominal pain	Yes	No
Nausea/vomiting	Yes	No
Indigestion/heartburn	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Bloody or dark stools	Yes	No
Change in bowels	Yes	No
Other		
COMMENTS:		

Sexual History		
Change in sex drive	Yes	No
Poor sexual performance	Yes	No
Other		
COMMENTS:		