

History Form – Initial Visit

NAME: (Mr./Mrs./Ms./Dr.) _____

Date of Birth: _____

CHIEF COMPLAINT (reason for visit):

Referring Doctor: _____ **Other doctors to receive copy of notes:** _____
Address, phone, and fax: _____ **Address phone and fax:** _____

1) How long have you had the problem? _____ 2) What other symptoms are related to this problem? _____

3) How bad is it? 0 1 2 3 4 5 6 7 8 9 10
Not bad----->Worst imaginable

4) How much does it affect your daily life? 0 1 2 3 4 5 6 7 8 9 10
No bother----->Can't function at all

5) Does it affect one area or move about (radiate?) _____
6) Do you already have a diagnosis for the problem? Yes (Please Indicate) No _____
7) What do YOU worry the problem might be? _____
8) What have you or other doctors/urologists done so far? (Records will help): _____

Urination: No problems
 Frequency every ___ hours while awake Nighttime voids ___ times per night Urgency
 Straining Incomplete emptying Urinary retention
 Post-void dribbling Difficulty starting stream Pain during void (describe):
 Stopping and starting Slow stream

Leakage: No
Leak Frequency: Constant 3+/day 1x/d 3x/wk 1x/wk 1x/mo Never wet
Cause: Coughing/Sneezing Sit to standing position Lifting
 Urge rushing to BR Temperature change Key in door
 Delayed emptying Only at night Only in day
 I am not sure I am just wet Cannot get to bathroom-mobility
Amount per leak: 1 drop 1 tablespoon 1 cup Entire Bladder
Management: Pads (# per day: _____, Type: _____) Change clothes/bed sheets Other: _____

Blood in the urine: Yes No
Urinary tract infection: Yes No How many in the past year?: _____ Did you have lab cultures? Yes (records useful) No

How are you managing your urine: Normal voiding With a tube in all the time Intermittent Catheterization _____ times per day
 Usual amount obtained: _____ ml or ounces
 Problems: _____

Bowels: Constipation managed by: _____ Irritable Bowel Syndrome Ulcerative Colitis Crohn's Disease
 Neurogenic Bowel managed by: Digital Stimulation Suppository Enema
 Fecal Incontinence: Small Stain Large amount requiring change of clothes No control

For Women, Pelvic Organ Prolapse: Sensation of bulge coming out of the vagina? Yes No Details: _____

Sexual Symptoms: No problems Not sexually active Lack of desire Poor arousal Poor orgasm
 Men: Unsatisfactory erections Bend Pain Prior treatments: _____
 Women: Dryness Surface Pain Pain deep inside Birth control method: _____
 I DO want treatment for sexual issues I DO NOT want treatment Relationship issues are a major factor
Do you worry you might be at risk for a sexually transmitted disease? Yes No If yes, why? _____

Reproductive Health
 # of children: ____ # biological children: ____ (If none: I chose not to have children I could not have children I have not decided)
 # of pregnancies: ____ # of live deliveries: ____ Outcome of other pregnancies: _____
Mode of delivery (check all that apply): Natural (vaginal) Forceps C-section Major tears or problems: _____
 Pre-menopausal Peri-menopausal Post-menopausal

Kidney (upper urinary tracts): No problems Pain I think is related to my kidney
 Current kidney stone Past kidney stone (Details: _____)
 Current or past kidney cancer (Details: _____)
 Renal insufficiency Renal failure (on dialysis) Prior kidney transplant

Pelvic Pain (area between hip bones):
 I do not have pelvic pain I have had pelvic pain for ____ years
 Prior treatments or diagnostic tests (records useful): _____

Social History:

Who lives with you, and what is their relation to you: _____
 Married Separated Divorced Widow Completely Single Live-in for ____ yrs Dating one Dating many
Sexual orientation: Straight (heterosexual) Gay /Lesbian (homosexual)

Occupation (Present or Prior): _____

Currently working: Yes (including homemaker) No: Retired Unemployed Disabled

Education: _____

Safety: Please tell us if you would like referral to a therapist. The 24 hour National Domestic Violence Hotline is: 1-800-799-SAFE (7233)

Have you ever been hit, hurt, threatened or abused? Yes No Currently? Yes No

Have you ever been sexually abused? Yes No Please alert us to your concerns regarding physical exam or testing.

Race/Ethnicity:

- White (European Caucasian) African American Asian non-Indian Asian-Indian / Middle Eastern
- Latino Caucasian Latino of Native American Origin
- Native American Tribe: _____ Other: _____

Review of Systems: CIRCLE if you have had any of these symptoms in the last FOUR MONTHS:

General:	Recent Illness (e.g. ER visit): _____			
General:	Fever	Chills	Itchiness	Rashes
	Breast lump	Skin lesions	Allergies	Immunity problems
Heart:	Chest pain, pressure	Shortness of breath with exertion	Ankle swelling	Pain in calves with exertion
	Needed >1 pillow to sleep	Awoke breathless at night	Noticed heart racing	
Lungs:	Cough: sputum, blood	Shortness of breath	Wheeze	Snored loudly
	Recent chest X-ray (describe results): _____			
GI:	Abdominal pain	Weight gain > 10 lbs	Weight Loss > 10 lbs	Bloating, distention
	Nausea	Vomiting	Blood in stool	Diarrhea
Neuro:	Change in vision	Change in hearing	Change in speech	Headaches
	Balance Trouble	Fainting	Dizziness	Tremors
	Weakness	Numbness	Concentration	Seizures
	Memory	Sleep disturbances	Blackouts	
Psych:	Depression	Anxiety	Other: _____	
Endocrine:	Intolerance hot weather	Intolerance to cold weather	Sweating	Fatigue
	Neck swelling	Hair changes	Voice changes	Thirst
Heme:	Difficulty stopping bleeds	Lumps under arms, neck, loin	History of clots in legs, lungs	
Rheum:	Joints: pain, stiffness	Fingers painful/ blue in cold	Dry mouth	Dry eyes
	Back pain	Neck pain	Prior work-up for back pain: _____	

RECENT PRIOR TESTING (records if possible):

Approximate Date/ Result/ Doctor/ Hospital:

LABS:	PSA	_____
	Creatinine	_____
	Urinalysis and Culture	_____
XRAYS (actual images please):	CT scan of the abdomen	_____
	IVP / VCUg	_____
	Ultrasound of the kidneys	_____
DIAGNOSTIC TESTING:	Cystoscopy	_____
	Urodynamics	_____
OTHER:	_____	

I have filled out this form to the best of my knowledge.

Signed,

Your Name _____
Date _____

Thank you very much for providing this information. We will do our absolute best to take care of your health care needs.