

Account # _____

UROLOGY CLINICS OF NORTH TEXAS

PATIENT MEDICAL INFORMATION

DATE: _____

NAME: _____ AGE: _____ REFERRING DOCTOR _____

PRIMARY CARE PROVIDER (PCP) _____

VITAL SIGNS: BP _____ Pulse _____ Resp _____
Temp _____ Wt _____ Ht _____

PAST MEDICAL HISTORY:

- Use of Coumadin... Yes No
High Blood Pressure... Yes No
Heart Attack... Yes No
Angina (chest pain related to heart disease)... Yes No
Arteriosclerosis (Hardening of the Arteries)... Yes No
Stroke... Yes No
Diabetes... Yes No
Asthma... Yes No
Pulmonary Emboli (Blood Clot in Lung)... Yes No
Tuberculosis... Yes No
Sickle Cell Trait/Disease... Yes No
Ulcers... Yes No
Parkinson's Disease... Yes No
Weight Loss... Yes No
Pacemaker Placement... Yes No
Arthritic Joints... Yes No
Heart Murmur... Yes No
If yes, do you take antibiotics for dental procedures? Yes No
Kidney Stones... Yes No
Elevated Cholesterol... Yes No
Hypothyroid (Low Thyroid)... Yes No
Depression... Yes No
Anxiety... Yes No

Other _____

SURGICAL HISTORY:

Table with 3 columns: Year, Operation, Hospital

DRUG ALLERGIES & REACTION:

Regular or daily use of Aspirin? Yes No

PLEASE LIST ALL OTHER MEDICATIONS BELOW:

Table with 3 columns: MEDICATION, STRENGTH, FREQUENCY

(continue on reverse side)

FAMILY HISTORY of kidney stones? Yes No

FEMALES ONLY

of pregnancies # of children
Last Menstrual Period? Date

MALES ONLY

History of Prostate Infections Yes No
Family History of Prostate Cancer? Yes No
When was your last prostate exam?
When was your last PSA test done?

SOCIAL HISTORY:

Do you or have you smoked Cigarettes?
Do you or have you abused alcohol?
Substance Abuse
Coffee
Tea
Carbonated Drinks
Water
Exercise Activity:
Occupation:

ROS: (URINARY HISTORY)

Frequency / Urgency
Burning or pain while voiding
Blood in Urine
Do you leak Urine
History of Urinary Tract Infections

Over the past month, how often have you:
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. had a sensation of not emptying your bladder completely after urinating?
2. had to urinate again less than two hours after you finished urinating?
3. found that you stopped and started again several times when you urinated?
4. found it difficult to postpone urination?
5. had a weak urinary stream?
6. had to push or strain to begin urination?
7. most typically gotten up to urinate from the time you went to bed at night until the time you got up in the morning?

Total score _____

PLEASE CONTINUE ON THE OTHER SIDE

In the following list, **please signify any problems which apply to you** with a check mark:

GENERAL	✓	EYES	✓	NECK	✓	BLOOD	✓
Recent weight gain/Amount		Pain		Swollen glands		Anemia	
Recent weight loss/Amount		Redness		Tender glands		Bleeding tendency	
Fatigue		Loss of vision		HEART AND LUNGS		SKIN	
Weakness		Double or blurred vision		Pain in chest		Easy bruising	
Fever		Dryness		Irregular heart beat		Redness	
Chills		Feels like something in eye		Sudden changes in heart beat		Rash	
Night sweats		NOSE		Shortness of breath		Hives	
Difficulty sleeping		Nosebleeds		Difficulty in breathing at night		Sun sensitive/sun allergy	
NERVOUS SYSTEM		Loss of smell		Swollen legs or feet		Tightness	
Headaches		Dryness		High blood pressure		Nodules/bumps? Where?	
Dizziness		MOUTH		Heart murmurs			
Fainting		Sore tongue		Cough		Hair loss	
Muscle spasm		Bleeding gums		Coughing of blood		Color changes of hands or feet in the cold	
Loss of consciousness		Sores in mouth		Wheezing			
Sensitivity or pain of hands and/or feet		Loss of taste		STOMACH AND INTESTINES		Mouth, nose, vaginal/penis sores (Indicate which)	
Memory loss		Dryness		Nausea			
Numbness/tingling? Where?		THROAT		Vomiting of blood or coffee ground material		MUSCLES/JOINTS/BONES	
		Frequent sore throats				Morning stiffness - Lasting how long?	
Weakness		Hoarseness		Stomach pain relieved by food or milk		____ Minutes	
Loss of urine/stool		Difficulty in swallowing		Yellow jaundice		____ Hours	
EARS		Date of last eye exam:		Constipation		Joint Pain	
ringing in ears				Persistent diarrhea		Muscle weakness	
Loss of hearing		Date of last chest X-Ray:		Blood in stools		Muscle tenderness	
				Black stools		Joint swelling - List joints affected in the last 6 months:	
				Heartburn			
				Trouble swallowing			

ADDITIONAL PATIENT INFORMATION:

FOR DOCTORS ONLY:

CHIEF COMPLAINT

PRESENT ILLNESS

PHYSICAL EXAM

PROCEDURES

LAB

ASSESSMENT

PLAN