

PATIENT NAME: _____ AGE: _____ Today's Date: _____

REASON FOR VISIT: _____

REQUESTING PHYSICIAN: _____

PERSONAL HISTORY:

Medication Allergy: Yes No List: _____

Iodine Allergy: Yes No Latex Allergy: Yes No

Allergic to Contrast used in imaging studies? Yes No

MEDICATIONS (Please include all drugs, i.e. Over-the-Counter, Non-Prescription or Herbal Drugs. Also, include any blood thinners such as Coumadin, Ticlid, Persantine, Plavix, or Aspirin):

Medication	Dosage	How Often?	Medication	Dosage	How Often?

Do you have any metal implants (such as plates, screws, clips, pacemaker, joints etc.)? Yes No

Do you have mitral valve prolapse or valvular disease? Yes No

Do you require premedication with antibiotics before a dental procedure? Yes No

Prior Hospital/Surgery: YEAR HOSPITAL SURGEON

SOCIAL HISTORY:

Have you ever smoked? Yes No Amount per day: _____ How long have you or did you smoke? _____ When did you quit smoking? _____

Your Occupation: _____

Do you drink alcohol? Yes No Amount per day: _____

Marital Status: Single Married Divorced Widowed

Do you have children? Yes No What are their ages: _____

Your Hobbies: _____

BLOODBORNE RISKS:

Have you ever had a blood transfusion? Yes No Have you ever injected illegal drugs? Yes No

Have you ever had Hepatitis? Yes No If yes, which type of Hepatitis? A B C Other

Have you ever had a positive blood test for HIV (AIDS)? Yes No

FAMILY HISTORY: LIVING DECEASED AGE CAUSE OF DEATH

Mother: _____

Father: _____

Siblings: _____

CONTINUED ON NEXT PAGE

UROLOGIC HISTORY Check Y (Yes) or N (No)

Y		N		Y		N		Y		N	
Blood In Urine				Kidney Stones				MALES ONLY			
Painful Urination/ Burning				Frequent Urinary Infections (UTI)				Blood in semen			
Urinary Frequency				Incontinence				Trouble with erections			
How often? _____ times per day				Leak urine when sneezing				Prior treatment for erection dysfunction			
Waking to urinate?				How many pads? _____ per day				Elevated PSA			
How often? _____ times per night				Aware of wetting				Problems with ejaculation			
Urinary Urgency				Venereal Disease				Decrease desire for sex			
Urine Retention				Urethral Discharge				Testicular Pain			
Intermittent stream				Vaginal Discharge				Ejaculatory Pain			
Feeling not completely emptying				Kidney Disease				Prostate infections			
Long wait or hesitation starting urinating				Bladder Repair Surgery				Enlarged Prostate/ BPH			
Straining or pushing to urinate/ Difficult Voiding/ Slow stream				Flank / Kidney Pain/ Abdominal Pain				Other: _____			

FAMILY HISTORY OF UROLOGIC DISEASE: _____

PAST MEDICAL HISTORY

Do you now or have you had any of the following in the past?
answers in space provided.

Please explain any Yes

Y		N		Y		N		Y		N	
Heart Attack				Diverticulitis				Seizures			
Abnormal Heart Beat				Irritable Bowel				Stroke			
Coronary Artery Disease				Liver Disease				Parkinson's Disease			
Elevated Cholesterol				Diabetes				Anemia			
High Blood Pressure				Thyroid Disease				Migraines			
Heart Murmur				Gout				GYNECOLOGIC (Females)			
Phlebitis				Asthma				Number of Pregnancies: _____			
Heart Failure				Bronchitis				Last Menstrual Period: _____			
Rheumatic Fever				Emphysema				Last GYN evaluation: _____			
Cancer of _____				Tuberculosis				Endometriosis			
Glaucoma				Pneumonia				Ectopic pregnancies			
Peptic Ulcers				Hay Fever				Abortions			
Colitis				Arthritis				Other GYN Concerns: _____			

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CURRENT MEDICAL CONDITIONS (Review of Systems)

Y N			Y N			Y N		
CARDIOVASCULAR			Constipation					
Chest Pain			Diarrhea			Tremors		
Swelling of Feet or ankles			Other GI Concerns			Numbness/Tingling		
Varicose Veins						Headaches		
CONSTITUTIONAL SYMPTOMS			EARS/NOSE/MOUTH/THROAT			Light Headed/Dizziness		
Fever						INTEGUMENTARY		
Fatigue			Hearing Loss			Skin Rash		
Weight Loss			Ear Infection			Boils		
Chills			Sinus Problems			Persistent Itch		
ENDOCRINE			Nose Bleeds			Breast Lumps		
Excessive Thirst			Sore Throat			HEMATOLOGIC/LYMPHATIC		
Hormone Problem			Swollen Glands/neck			Swollen Glands		
Too Hot/Cold						Blood Clotting Problem		
EYES						Easy Bleeding/Bruising		
Blurred Vision			MUSCULOSKELETAL			PSYCHIATRIC		
Double Vision			Muscle Weakness			Memory Loss		
Eye Pain			Neck or Back Pain/Problems			Depression		
GASTROINTESTINAL			Joint Pain			Anxiety		
Abdominal Pain			LUNGS			Insomnia		
Nausea/Vomiting			Chronic Cough			Considered suicide?		
Indigestion/Heartburn			Spitting Up Blood			Dissatisfied with life?		
Loss of Appetite			Wheezing			Severely depressed?		
Rectal Bleeding			Shortness of Breath					

Please explain all "Y" (Yes) answers:

Details of ROS (To be completed by Physician):

Physician Signature: _____ **Date:** _____