

# SUNCOAST UROLOGY, P.A.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

1. State the reason or symptom that brought you to the urologist today.

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2. Have you ever seen a urologist before or had urologic problems requiring treatments in the past?

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3. What medical problems do you have or have you had in the past that required treatment by a doctor or in a hospital?

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|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

4. What surgeries have you had (please include all surgeries and dates)?

- |          |          |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

5. What medications (including over the counter medications, aspirin, antiinflammatories, vitamins, herbs, etc.) do you take and include dosages if possible?

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|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

6. What medication allergies do you have?

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|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |

7. Are you allergic to seafood or iodine? \_\_\_yes \_\_\_no

8. Have any members of your family had urologic problems? (For example, kidney stones, prostate, bladder or kidney cancers, frequent urinary tract infections etc.)

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9. Do any other medical problems run in your family? (e.g., Diabetes, heart disease, cancer, etc. If so, specify relationship.

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10. Please indicate the quantity of consumption per day of the following:

- a. Tobacco:
- b. Alcohol
- c. Coffee (specify caffeinated or decaffeinated)
- d. Tea (specify caffeinated or decaffeinated)
- e. Soda (specify caffeinated or decaffeinated)
- f. Citrus products

11. Marital Status: S/D/W/M

12. Occupation (if retired, specify your occupations prior to retirement):

### Review of Systems

Do you now or have you had any problems related to the following systems: Circle Yes or NO.  
Please explain any yes answers in space provided.

#### Constitutional Symptom

Fever Y N  
Chills Y N  
Headache Y N  
Other \_\_\_\_\_

#### Eyes

Blurred vision Y N  
Double vision Y N  
Pain Y N  
Other \_\_\_\_\_

#### Allergic/Immunologic

Hay fever Y N  
Drug allergies Y N  
Other \_\_\_\_\_

#### Neurological

Tremors Y N  
Dizzy spells Y N  
Numbness/tingling Y N  
Other \_\_\_\_\_

#### Endocrine

Excess thirst Y N  
Too hot/too cold Y N  
Tired/sluggish Y N  
Other \_\_\_\_\_

#### Gastrointestinal

Abdominal pain Y N  
Nausea/vomiting Y N  
Indigestion/heartburn Y N  
Other \_\_\_\_\_

#### Cardiovascular

Chest pain Y N  
Varicose veins Y N  
High blood pressure Y N  
Other \_\_\_\_\_

#### Integumentary

Skin rash Y N  
Boils Y N  
Persistent itch Y N  
Other \_\_\_\_\_

#### Musculoskeletal

Joint pain Y N  
Neck pain Y N  
Back pain Y N  
Other \_\_\_\_\_

#### Ear/Nose/Throat/Mouth

Ear infection Y N  
Sore throat Y N  
Sinus problems Y N  
Other \_\_\_\_\_

#### Genitourinary

Urine retention Y N  
Painful urination Y N  
Urinary frequency Y N  
Other \_\_\_\_\_

#### Respiratory

Wheezing Y N  
Frequent cough Y N  
Shortness of breath Y N  
Other \_\_\_\_\_

#### Hematologic/Lymphatic

Swollen glands Y N  
Blood clotting problems Y N  
Other \_\_\_\_\_

#### Psychologic

Are you generally satisfied with your life? Y N  
Do you feel severely depressed Y N  
Have you considered suicide Y N  
Other \_\_\_\_\_