Urology Specialty Group

A Division of U.S.S.C.

MRN #_____ Urochart Intake Form

Patient Name: _____ **Date:** _____

Who referred you to this office? _____ **Medical Doctor/PCP:** _____

Why are you seeing the physician today: _____

When did your problem start: _____ **Pharmacy** (Name & Number)**:** _____

My Main Problems are:

☐ Blood in urine ☐ Bladder Cancer ☐ Bladder Infection ☐ Bladder Pain ☐ Dropped Bladder
☐ Kidney Stones ☐ Interstitial Cystitis ☐ Leak Urine ☐ Overactive Bladder
☐ Other _____

Allergies ☐ None ☐ PCN ☐ Sulfa ☐ Cipro ☐ Iodine/contrast
☐ Other _____

Medications ☐ None ☐ Aspirin ☐ Lortab ☐ Percocet ☐ Plavix ☐ Nitroglycerin
☐ Detrol ☐ Detrol LA ☐ Vesicare ☐ Allopurinol ☐ Coumadin
Antibiotic: _____ ☐ Other: _____

Surgical History ☐ Appendectomy ☐ Back/Hip/Knee ☐ Bladder Tack ☐ C – Section # _____
☐ Cystoscopy ☐ Gallbladder ☐ Heart Bypass ☐ Hysterectomy ☐ Kidney Stone Surgery
☐ Lithotripsy ☐ Sling (TVT) ☐ Vaginal Deliveries # ____ ☐ Other _____
☐ **No Changes**

Medical History ☐ Diabetes ☐ Emphysema ☐ Heart Attack ☐ Heart Murmur
☐ Hepatitis ☐ Hernia ☐ Hypertension ☐ Last Period: _____ ☐ Menopause
☐ Parkinson's ☐ Pregnant ☐ Strokes ☐ Cancer: _____
☐ Other _____ ☐ **No Changes**

Family History ☐ Kidney Cancer ☐ Kidney Stones ☐ Heart Disease

Social History (Circle One)

Marital Status: *Single Married Divorced Widowed* Smoke: *Yes Not Anymore Never*
Drink Alcohol: *Yes Not Anymore Never* Daily Caffeine Intake: *0 1 2 3 4+*
Blood Transfusion: *YES NO*

My Symptom(s) are:

General/Constitutional	☐ Fever	☐ Weight Loss	☐ Chills
Eyes	☐ Blurry Vision	☐ Double Vision	☐ Cataracts
Ears, Nose, Mouth, Throat	☐ Hearing Loss	☐ Nasal Stuffiness	☐ Sore Throat
Cardiovascular	☐ Chest Pains	☐ Swollen Ankles	☐ Irregular Heartbeat
Respiratory	☐ Shortness of Breath	☐ Wheezing	☐ Chronic Cough
Gastrointestinal	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Change in Bowels
Genitourinary	☐ Incontinence	☐ Painful Urination	☐ Blood in Urine
Musculoskeletal	☐ Chronic Back Pain	☐ Chronic Neck Pain	☐ Sore Muscles
Integumentary/Skin	☐ Rash	☐ Persistant Itching	☐ Skin Cancer History
Neurologic	☐ Numbness	☐ Tingling	☐ Dizziness
Hematologic/Lymphatic	☐ Swollen Glands	☐ Abnormal Bleeding	☐ Transfusion History

Urinary Symptom(s) are:

☐ Frequency ☐ Urgency ☐ Leakage ☐ Straining
☐ Abdominal Pain ☐ Bladder Pain ☐ Pain in Side R / L ☐ Not Emptying Bladder
☐ Urinating at Night #_____