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:

☐ Enlarged Prostate ☐ Blood in urine ☐ High PSA ☐ Bladder Infection
☐ Kidney Stones ☐ Prostate Infection ☐ Urinary Incontinence ☐ Bladder Cancer
☐ Prostate Cancer ☐ Erectile Dysfunction ☐ Overactive Bladder ☐ Infertility
☐ Lump in Testicle ☐ Other _____

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

Medications ☐ None ☐ Aspirin ☐ Avodart ☐ Cardura ☐ Coumadin ☐ Flomax
☐ Hytrin ☐ Lupron ☐ Nitroglycerin ☐ Plavix ☐ Proscar ☐ Uroxatrol ☐ Vesicare
☐ Viagra ☐ Cialis ☐ Levitra ☐ Zoladex
Antibiotic: _____ ☐ Other: _____

Surgical History ☐ Appendectomy ☐ Back/Hip/Knee ☐ Cystoscopy ☐ Gallbladder
☐ Heart Bypass ☐ Kidney Stone Surgery ☐ Lithotripsy ☐ Prostate Biopsy ☐ Prostate Seed
☐ Prostate Surgery ☐ Other _____ ☐ **No Changes**

Medical History ☐ Diabetes ☐ Emphysema ☐ Heart Attack ☐ Heart Murmur
☐ Hepatitis ☐ Hernia ☐ Hypertension ☐ Parkinson's ☐ Strokes
Cancer: ☐ Prostate ☐ Kidney ☐ Testis ☐ Other _____ ☐ **No Changes**

Family History ☐ Prostate Cancer ☐ 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:

☐ Incomplete Emptying ☐ Frequency ☐ Intermittency ☐ Weak Stream ☐ Straining
☐ Testicle Pain ☐ Pain in Side R / L ☐ Urinating at Night # _____