

# WESTERN UROLOGICAL CLINIC

4252 South Highland Drive #200 • Salt Lake City, Utah 84124

Note: This confidential record will be kept in your doctor's office. Information contained in this form will not be released without your consent.

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Your Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Physician \_\_\_\_\_ Your Family Physician \_\_\_\_\_

Your Occupation \_\_\_\_\_ Retired ? YES NO

## Chief Complaint

What is the main reason for your visit to the Urologist? (Describe your problems in detail) \_\_\_\_\_

Physicians Use Only: (Comments / Notes)

AUA Symptom Score: \_\_\_\_\_

## PAST MEDICAL AND SOCIAL HISTORY

Check the appropriate response in each column

### Do You Have a History of:

Diabetes	Yes	No
Heart Disease	Yes	No
Cancer	Yes	No
High Blood Pressure	Yes	No
Kidney Stones	Yes	No
Stroke	Yes	No
Bleeding Disorder	Yes	No
Breathing Problems	Yes	No

### Does Your family Have a History of:

Diabetes	Yes	No
Prostate Cancer	Yes	No
Bladder Cancer	Yes	No
Kidney Cancer	Yes	No
Circulation Problems	Yes	No
Heart Disease	Yes	No
Mother Living?	Yes	No
Father Living?	Yes	No

Cause of Death (Mother) \_\_\_\_\_ Age \_\_\_\_\_

Cause of Death (Father) \_\_\_\_\_ Age \_\_\_\_\_

### List all Surgeries and Dates of Procedures

\_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

### List all of Your Current Prescribed and Over the Counter Medications:

(Please include Aspirin, Vitamins, Supplements, Sinus / allergy medications, etc.)

Drug Name & Dose: \_\_\_\_\_ Drug Name & Dose: \_\_\_\_\_

Drug Name & Dose: \_\_\_\_\_ Drug Name & Dose: \_\_\_\_\_

Drug Name & Dose: \_\_\_\_\_ Drug Name & Dose: \_\_\_\_\_

Drug Name & Dose: \_\_\_\_\_ Drug Name & Dose: \_\_\_\_\_

Are You ALLERGIC to any medications? Yes No  
If yes, Please list the medications you are allergic to:

Marital Status: \_\_\_\_\_ Married Single  
Number of children? \_\_\_\_\_

Have you ever smoked? Yes No  
If yes, how long have you smoked? \_\_\_\_\_  
If yes, how long ago did you quit? \_\_\_\_\_

Do you drink alcohol? Yes No  
If yes, do you drink Daily? Weekly? Social Only?

Physicians Use Only: (Comments / Notes)

### Review of Body Systems

Please identify if you currently have, or have ever experienced any of the problems related to the following systems:

#### Constitutional Symptoms

Fever	Yes	No
Chills	Yes	No

#### Gastrointestinal Symptoms

Abdominal Pain	Yes	No
Nausea/Vomiting	Yes	No
Indigestion	Yes	No
Abdominal Cramping	Yes	No

#### Cardiovascular Symptoms

Chest Pain	Yes	No
Hypertension	Yes	No
Heart Attack	Yes	No
High Cholesterol	Yes	No
Pacemaker or Valve	Yes	No

#### Neurological Symptoms

Tremors	Yes	No
Difficulty Walking	Yes	No

#### Genitourinary Symptoms

Urine Retention	Yes	No
Painful Urination	Yes	No
Blood In Urine	Yes	No
Urinary Frequency	Yes	No
Urinary Leaking	Yes	No
Urinary Urgency	Yes	No
Kidney Stones	Yes	No
Sexually Active	Yes	No
Sexual Problems	Yes	No

Patients Name \_\_\_\_\_ Date: \_\_\_\_\_

**Integumentary Symptoms**

Skin Rash Yes No  
Persistent Itch Yes No

**Musculoskeletal Symptoms**

Joint Pain Yes No  
Neck Pain Yes No  
Back Pain Yes No

**Hematologic/Lymphatic Symptoms**

Swollen Glands Yes No  
Blood Clotting Yes No  
Problems Yes No

**Endocrine Symptoms**

Weight Loss / Gain Yes No  
Excessive Thirst Yes No  
Hot / Cold Spells Yes No

**Respiratory Symptoms**

Wheezing Yes No  
Frequent Cough Yes No  
Shortness of Breath Yes No

**Gynecological Symptoms (Females Only)**

Vaginal Discharge Yes No  
Vaginal Discomfort or Pain Yes No  
Unexplained Vaginal Bleeding Yes No  
Number of Pregnancies \_\_\_\_\_  
Number of Vaginal Deliveries \_\_\_\_\_  
Date of Last Menstrual Period \_\_\_\_\_  
Date of Last PAP Smear \_\_\_\_\_  
Date of Last Mammogram \_\_\_\_\_  
Do you Use Estrogen / Hormone Replacement Yes No  
Type of Birth Control \_\_\_\_\_  
Could you be Pregnant? \_\_\_\_\_

Physicians Use Only: (Comments / Notes)

Is there any additional information that you feel your physician should know?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician Signature: \_\_\_\_\_

Review Dates: \_\_\_\_\_ (Place Stamp Here)

Patients Name \_\_\_\_\_ Date: \_\_\_\_\_