

**TO BE COMPLETED BY PATIENT**

**UROLOGIC HISTORY**

Please Check

- |   |   |   |
|---|---|---|
| ___ # Urinate/day                               | <input type="checkbox"/> Delay in starting to urinate   | <input type="checkbox"/> Pads per day     |
| ___ # Urinate/night                             | <input type="checkbox"/> Interrupted stream             | <input type="checkbox"/> Kidney stones    |
| <input type="checkbox"/> Urgent need to urinate | <input type="checkbox"/> Slow/weak stream               | <input type="checkbox"/> Discharge        |
| <input type="checkbox"/> Burning Pain           | <input type="checkbox"/> Dribble after urinating        | <input type="checkbox"/> Back pain        |
| <input type="checkbox"/> Blood in urine         | <input type="checkbox"/> Felling of incomplete emptying | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Straining to urinate   | <input type="checkbox"/> Leakage of urine               |   |
| <input type="checkbox"/>                        | <input type="checkbox"/>                                |   |

UROLOGIC SURGERY: \_\_\_\_\_  
(and date of each) \_\_\_\_\_

**FLUID INTAKE (Amt.) daily**

Water \_\_\_\_\_ Pop \_\_\_\_\_  
Coffee \_\_\_\_\_ Milk/Juice \_\_\_\_\_  
Alcohol \_\_\_\_\_

**URINARY TRACT INFECTIONS**

\_\_\_\_\_ # in last year  
\_\_\_\_\_ :date of last infection

**DIAGNOSED MEDICAL ILLNESSES**

Check all conditions you have had: (x)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Multiple Sclerosis              |
| <input type="checkbox"/> Cataracts                  | <input type="checkbox"/> Rheumatoid arthritis  | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Osteoarthritis        | <input type="checkbox"/> Parkinson's Disease             |
| <input type="checkbox"/> Bronchitis                 | <input type="checkbox"/> Pneumonia             | <input type="checkbox"/> Seizures Disorder               |
| <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Psychiatric           | <input type="checkbox"/> Alzheimer's Disease             |
| <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Anemia                          |
| <input type="checkbox"/> Arrhythmia                 | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Phlebitis                       |
| <input type="checkbox"/> Coronary Artery Disease    | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Disease                 |
| <input type="checkbox"/> Murmur                     | <input type="checkbox"/> Colitis               | <input type="checkbox"/> Diabetes: Insulin - Non-insulin |
| <input type="checkbox"/> hepatitis (past or active) | <input type="checkbox"/> Alcohol Abuse         | <input type="checkbox"/> Hormone Disease                 |
| <input type="checkbox"/> Ulcers                     | <input type="checkbox"/> Drug Abuse            | <input type="checkbox"/> Cancer _____                    |
| <input type="checkbox"/> Gall Stones                | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Other Disease not listed        |
| <input type="checkbox"/> Fibromyalgia               | <input type="checkbox"/> Disc Disease          | _____  |
| <input type="checkbox"/> COPD                       | <input type="checkbox"/> CHF                   | _____  |

**PAST MEDICAL HISTORY**

HOSPITALIZATIONS \_\_\_\_\_  
\_\_\_\_\_

OPERATIONS/TREATMENTS \_\_\_\_\_

INJURIES \_\_\_\_\_

ALLERGIES & REACTION \_\_\_\_\_

MEDICATIONS \_\_\_\_\_

(Names & Dose) \_\_\_\_\_

**SOCIAL HISTORY**

Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_ Smoking  Yes \_\_\_ packs/day  
 No quit \_\_\_ (yr)

**FAMILY HISTORY**

MOTHER \_\_\_ Alive \_\_\_ Deceased \_\_\_ Age Health Problems \_\_\_\_\_  
FATHER \_\_\_ Alive \_\_\_ Deceased \_\_\_ Age Health Problems \_\_\_\_\_  
BROTHERS \_\_\_ Alive \_\_\_ Deceased \_\_\_ Age Health Problems \_\_\_\_\_  
SISTERS \_\_\_ Alive \_\_\_ Deceased \_\_\_ Age Health Problems \_\_\_\_\_

**GENITO-URINARY SURGEONS, INC.  
INITIAL PATIENT EVALUATION FORM  
FEMALE**

**TO BE COMPETED BY DOCTOR**

DATE: \_\_\_\_\_ DOB: \_\_\_\_\_ CHART# \_\_\_\_\_

NAME: \_\_\_\_\_

CC & HPI: (Brief 1-3; Extended >4)

Location

Quality

Severity

Duration

Context

Modifying Factors

Associated Signs & Symptoms

SYMPTOMS: Frequency: x \_\_\_\_\_, urgency, UI, dysuria, nocturia: x \_\_\_\_\_, enuresis, SUI, hesitancy, straining, intermittency, FOS, incomplete emptying, dribbling: \_\_\_\_\_ pads, \_\_\_\_\_ fluids/day, UTI's hematuria, stones, bowel symptoms, introital bulging, pain, dyspareunia, neurological symptoms.

OBSTETRICAL HISTORY: GPA  
LMP

VAG/ABD HYSTERECTOMY  
MENSTRUAL HISTORY

**PHYSICAL EXAM:**

CVAT R \_\_\_\_\_ L \_\_\_\_\_

External Genitalia

Abdomen

Urethra

Bladder

Bimanual Exam

Speculum Exam

**IMPRESSIONS:**

**PLAN:**