**UROLOGIC HISTORY**

**INITIAL PATIENT EVALUATION FORM - MALE**

- Please check box if it applies to you:

  - Urgent need to urinate
  - Delay in starting to urinate
  - Feeling of incomplete emptying
  - Burning pain
  - Blood in urine
  - Straining to urinate
  - Urgent need to urinate
  - Slow/weak stream
  - Feeling of incomplete emptying
  - Burning pain
  - Interrupted stream
  - Leakage of urine
  - Kidney stones
  - Impotence
  - Back pain
  - Blood in urine
  - Slow/weak stream
  - Leakage of urine
  - Venereal disease
  - Testicular pain/swelling

**UROLOGIC SURGERY**

**DATE OF SURGERY**

Date of surgery:

**FLUID INTAKE (Amt.) daily**

- Water: 
- Milk/Juice: 
- Coffee: 
- Alcohol: 
- Pop: 

**URINARY TRACT INFECTIONS**

- Number in last year: 
- Date of last infection: 

**DIAGNOSED MEDICAL ILLNESSES**

- Please check all conditions you have had:

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

**PAST MEDICAL HISTORY**

- Hospitalizations:
- Operations/Treatments:
- Injuries:
- Allergies & Reaction/s:
- Medication/s:
  - Name of Medication
  - Dosage

Form: Male Evaluation.doc
SOCIAL HISTORY

Occupation ________________________________________________________________

Marital Status  □ Single  □ Married  □ Divorced  □ Widow

Smoking  □ Yes  □ No  If Yes, how many packs per day? __________________________________________

If you were a previous smoker, when did you quit? (year) ________________________

FAMILY HISTORY

MOTHER  □ Alive  □ Deceased  Age _____  Health Problems __________________________________________

FATHER  □ Alive  □ Deceased  Age _____  Health Problems __________________________________________

BROTHER □ Alive  □ Deceased  Age _____  Health Problems __________________________________________

SISTER □ Alive  □ Deceased  Age _____  Health Problems __________________________________________
Patient Name__________________________
Patient Number________________________

TO BE COMPLETED 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, ____________, fluids/day, UTI's 
hematuria, stones, erectile, bowel symptoms, 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: