West Shore Urology, P.L.C.

NEW PATIENTS
MALE

Today's Date: _____

Name: _____ **DOB:** _____

Sex: _____ **Height:** _____ **Weight:** _____

Preferred Pharmacy: _____ **Referring Provider:** _____

What is your primary complaint?

_____

_____

How long have you had this problem?

_____

MEDICATIONS Currently taking with dosages:

_____

Do you take blood thinners?

_____

ALLERGIES Updates/Changes/Reaction:

_____

Review of Systems:

Have you experienced any of the following within the last 30 days? (circle Yes / No)

Constitutional

Chills	No / Yes
Fever	No / Yes
Weight Loss	No / Yes

HEENT

Blurred Vision	No / Yes

Respiratory

Short of Breath	No / Yes

Cardiovascular

Chest Pain	No / Yes

Gastrointestinal

Abdominal Pain	No / Yes
Blood in Stool	No / Yes
Constipation	No / Yes
Diarrhea	No / Yes
Nausea	No / Yes
Vomiting	No / Yes

Genitourinary

Painful Urination	No / Yes
Blood in Urine	No / Yes
Urinary Frequency	No / Yes
Urinary Urgency	No / Yes
Urinary Incontinence	No / Yes
Unable to Empty Bladder	No / Yes

Reproductive

Penile Discharge (male)	No / Yes
Sexual Dysfunction (male)	No / Yes

Psych

Anxiety	No / Yes
Depression	No / Yes

Integumentary

Rash	No / Yes

Musculoskeletal

Back Pain	No / Yes

Hematologic

Easy Bleeding	No / Yes
Swollen Lymph Nodes	No / Yes

Past Medical:

In addition to what is listed above, please check all, if any, that apply below:

Angina	☐	Kidney Stones	☐	Depression	☐
Asthma	☐	Liver Disease	☐	Hernia Type _____	☐
COPD	☐	Stroke	☐	Irritable Bowel Syndrome	☐
Atrial Fibrillation	☐	Thyroid Disease	☐	Urinary Tract Infection	☐
Diabetes Type I or II	☐	Reflux (Esophageal)	☐	Sleep Apnea	☐
Heart Attack (MI)	☐	Glaucoma	☐	Cancer Type _____	☐
Hepatitis A, B, C	☐	Bleeding Disorder	☐	Muscle Aches	☐
High Blood Pressure	☐	Type _____		HIV/AIDS	☐
Irreg./Rapid Heartbeat	☐	Chronic Diarrhea	☐	Vascular Type _____	☐
Kidney Disease	☐	Chronic Constipation	☐	Pacemaker	☐

Surgery:		Year	Surgery:		Year
ESWL (Lithotripsy)	☐	_____	Prostatectomy	☐	_____
Heart Surgery Type _____	☐	_____	TURP	☐	_____
Nephrectomy (Kidney Removal)	☐	_____	Gall Bladder	☐	_____
Penile Implant	☐	_____	Spleen Removed	☐	_____
Prostate Biopsy	☐	_____	Urinary Sphincter	☐	_____
Joint Surgeries	☐	_____	Vasectomy	☐	_____
Please Specify: _____			Appendix Removed	☐	_____
Adnoids Removed	☐	_____	Tonsils Removed	☐	_____
			Vascular Type _____	☐	_____

Other Medical Problems/Other Surgeries:

_____

_____

_____

_____

_____

Family History:		Family Member			Family Member
Bladder Cancer	☐	_____	Prostate Cancer	☐	_____
Kidney Cancer	☐	_____	Kidney Stones	☐	_____
Diabetes	☐	_____			

Other Family History:

Mother _____

Father _____

All alive and well _____

Social History:

Do you currently use tobacco? No / Yes Type: _____ Amount per day: _____ Age Started: _____

Have you ever used tobacco? No / Yes Type: _____ Age Stopped: _____

Alcohol Use: No / Yes / Former Type: _____ How Often: _____

Caffeine Use: No / Yes / Former Type: _____ How Often: _____

Males Only:

Please CIRCLE the appropriate number for each category:	Not at All	Less than one time in five	Less than half time	About half the time	More than half the time	Almost always
Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5
Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Over the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
How many times do you most typically get up to urinate from the time you go to bed at night until the time you get up in the morning?	0	1	2	3	4	5

Quality of Life Due to Urinary Symptoms:

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?

☐ Delighted ☐ Pleased ☐ Mostly Satisfied ☐ Mostly Dissatisfied ☐ Unhappy ☐ Terrible ☐ Mixed

I certify that the information on this form is correct to the best of my knowledge.

Patient's Signature: _____ Today's Date: _____