PLEASE PRINT WITH BLOCK LETTERS

COMPLETE ❑
ABBREVIATED ❑

Dallas Urology Associates, L.L.P.

Practice Limited to Urology

Patient Medical Information

Date: ___________

NAME: _________________________ DATE:______________ AGE:______ PRIMARY DOCTOR:___________________________

HOW WERE YOU REFERRED? ❑ Primary Doctor ❑ Specialist Doctor_____________________ ❑ Friend ❑ Insurance ❑ Other

VITAL SIGNS: BP ______ Pulse ______ Resp ______
Temp ______ Wt __________ HI ______

____

PAST MEDICAL HISTORY:

- Use of Coumadin .... ☐ Yes ☐ No
- Regular or daily use of Aspirin .... ☐ Yes ☐ No
- High Blood Pressure .... ☐ Yes ☐ No
- Heart Attack .... ❑ Yes ☐ No
- Angina (Chest pain) .... ❑ Yes ☐ No
- Arteriosclerosis (Hardening of the Arteries) ❑ Yes ☐ No
- Stroke .... ☐ Yes ☐ No
- Diabetes .... ❑ Yes ☐ No
- Asthma .... ❑ Yes ❑ No
- Pulmonary Emboli (Blood Clot in Lung) . ❑ Yes ☐ No
- Tuberculosis .... ❑ Yes ☐ No
- Sickle Cell Trait/Disease .... ❑ Yes ❑ No
- Ulcers .... ☐ Yes ☐ No
- Parkinson's Disease .... ☐ Yes ❑ No
- Weight Loss .... ❑ Yes ☐ No
- Pacemaker Placement .... ☐ Yes ☐ No
- Arthritic Joints .... ❑ Yes ❑ No
- Heart Murmur .... ☐ Yes ☐ No
- Kidney Stones .... ☐ Yes ☐ No
- Elevated Cholesterol .... ❑ Yes ☐ No

Other ____

SURGICAL HISTORY:

Year	Operation	Hospital

DRUG ALLERGIES & REACTION: ____________________
____

MEDICATION	STRENGTH	FREQUENCY

(Continue on reverse side)

FAMILY HISTORY of kidney or bladder problems? ❑ Yes ❑ No

FEMALES ONLY

\# of pregnancies__________# of children________
Last Menstrual Period? . . . Date _______________

MALES ONLY

History of Prostate Infections .... ❑ Yes ❑ No
Family History of Prostate Cancer? .... ❑ Yes ❑ No
When was your last prostate exam?_________________
When was your last PSA test done?_________________

SOCIAL HISTORY:

		Quantity
Cigarettes	☐ Yes ☐ No Quit ______	______
Alcohol	☐ Yes ☐ No Quit ______	______
Substance Abuse .	☐ Yes ☐ No Quit ______	______
Coffee	☐ Yes ☐ No	
Tea	☐ **Yes** ❑ No	
Carbonated Drinks	☐ **Yes** ☐ No	
Water...........................	☐ Yes ☐ No	

Exercise Activity: ____

Occupation: ____

ROS: (URINARY HISTORY)

- Frequency .... ☐ Yes ☐ No
- Urgency .... ☐ Yes ☐ No
- Burning or pain while voiding .... ☐ Yes ☐ No
- Blood in Urine .... ☐ Yes ☐ No
- Do you leak Urine? .... ☐ Yes ☐ No
- History of Urinary Tract Infections .... ☐ Yes ☐ No
- History of Kidney Stones .... ☐ Yes CI No

Over the past month, how often have you:

0=Not at all, 1=Less than 1 time in 5, 2= Less than half the time, 3= About half the time, 4= More than Half the time, 5= Almost always

1. had a sensation of not emptying your bladder completely after urinating?	0	1	2	3	4	5
2. had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. found that you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. found it difficult to postpone unnation?	0	1	2	3	4	5
5 had a weak urinary stream?	0	1	2	3	4	5
6. had to push or strain to begin urination?	0	1	2	3	4	5
7. most typically gotten up to urinate from the time you went to bed at night until the time you got up in the morning? (number of times)	0	1	2	3	4	5

Total score: ___________

PLEASE CONTINUE ON THE OTHER SIDE

In the following list, please signify any problems which apply to you with a check mark:

GENERAL	✓	EYES	✓	NECK	✓	BLOOD	✓
Recent weight gain/Amount		Pain		Swollen glands		Anemia	
Recent weight loss/Amount		Redness		Tender glands		Bleeding tendency	
Fatigue		Loss of vision		**HEART AND LUNGS**		SKIN	
Weakness		Double or blurred vision		Pain in chest		Easy bruising	
Fever		Dryness		Irregular heart beat		Redness	
Chills		Feels like something in eye		Sudden changes in heart beat		Rash	
Night sweats		**NOSE**		Shortness of breath		Hives	
Difficulty sleeping		Nosebleeds		Difficulty in breathing at night		Sun sensitive/sun allergy	
NERVOUS SYSTEM		Loss of smell		Swollen legs or feet		Tightness	
Headaches		Dryness		High blood pressure		Nodules/bumps? Where?	
Dizziness		**MOUTH**		Head murmurs			
Fainting		Sore tongue		Cough		Hair loss	
Muscle spasm		Bleeding gums		Coughing of blood		Color changes of hands or feet in the cold	
Loss of consciousness		Sores in mouth		Wheezing			
Sensitivity or pain of hands and/or feel		Loss of taste		**STOMACH AND INTESTINES**		Mouth, nose, vaginal/penis sores (Indicate which)	
Memory loss		Dryness		Nausea			
Numbness/tingling? Where?		THROAT		Vomiting of blood or coffee ground material		**MUSCLES/JOINTS/BONES**	
		Frequent sore throats				Morning stiffness - Lasting how long?	
Weakness		Hoarseness		Stomach pain relieved by food or milk			
Loss of urine/stool		Difficulty in swallowing		Yellow jaundice			
EARS		Date of last eye exam:		Constipation		Joint Pain	
Ringing in ears				Persistent diarrhea		Muscle weakness	
Loss of hearing		Date of last chest X-Ray:		Blood a stools		Muscle tenderness	
				Black stools		Joint swelling - List joints affected in the last 6 months:	
				Heartburn			
				Trouble swallowing			

ADDITIONAL PATIENT INFORMATION:

FOR DOCTORS ONLY:

CHIEF COMPLAINT

PRESENT ILLNESS

PHYSICAL EXAM

PROCEDURES

LAB

ASSESSMENT

PLAN