

**PRESENT ILLNESS:**

What is the main reason for your visit today? Please describe problem in detail.

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**FOR OFFICE USE ONLY:**

Stream \_\_\_\_\_  
Hesitancy \_\_\_\_\_  
Dribbling \_\_\_\_\_  
Nocturia \_\_\_\_\_  
Hematuria \_\_\_\_\_  
Dysuria \_\_\_\_\_  
Urgency \_\_\_\_\_  
Stress incont. \_\_\_\_\_  
Urge incont. \_\_\_\_\_  
Incomp. Voiding \_\_\_\_\_  
Daily H2O intake \_\_\_\_\_  
GC or NSU \_\_\_\_\_  
Enuresis as child \_\_\_\_\_  
Abdominal surgery: \_\_\_\_\_

Male sexual function: \_\_\_\_\_

PSA & DATE: \_\_\_\_\_

Vasectomy: Yes No

Sugar or albumin in urine; urinary tract infections; stone or other disorder of kidney, bladder, prostate, or reproductive organs. \_\_\_\_\_

**FOR OFFICE USE ONLY:**

IVP

CXR

EKG

DATE: \_\_\_\_\_

WHERE: \_\_\_\_\_

CURRENT MEDS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ TEMP \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

ROUTINE URINALYSIS: COLOR \_\_\_\_\_ S.G. \_\_\_\_\_ SUGAR \_\_\_\_\_ PROTEIN \_\_\_\_\_ pH \_\_\_\_\_ HEMA \_\_\_\_\_

WBC'S \_\_\_\_\_ RBC'S \_\_\_\_\_ BACTERIA \_\_\_\_\_



**PHYSICAL EXAMINATION:**

<b>Systems/Body Areas: Elements</b>	<b>Check here for Normal</b>	<b>Assessment is <u>Abnormal</u> as described below:</b>
<b>Constitutional</b> Vital Signs: General Appearance:	  	BP(sitting) ___ BP supine) ___ T ___ P ___ R ___ HT ___ WT ___ Development: _____ Nutrition: _____ Deformities: _____ Grooming: _____
<b>Neurological/Psychiatric</b> Orientation: Mood & Affect:	  	Time ___ Place ___ Person ___ Other _____ Depression _____ Anxiety _____ Agitation _____
<b>Skin</b> Inspection and/or palpation	 	Pale ___ Jaundice ___ Cyanosis ___ Turgor ___ Hydration ___ Texture ___ Rash ___ Lesions ___
<b>Neck</b> Neck: Thyroid:	  	Symmetry ___ Swelling ___ Tenderness ___ Size ___ Tenderness ___ Nodules ___
<b>Respiratory</b> Respiratory Effort: Auscultation:	  	Labored ___ Diaphragmatic ___ Abdominal ___ Rales ___ Rhonchi ___ Wheezes ___ Rubs ___
<b>Cardiovascular</b> Auscultation: Peripheral:	  	Rhythm ___ Murmurs ___ Rubs ___ Other ___ Swelling ___ Varicosities ___ Pedal Pulse ___ Temperature ___ Tenderness ___ Other ___
<b>Lymphatic</b> Palpatation:	 	<i>Two (2) or more</i> Neck: Size ___ Tenderness ___ Axillae: Size ___ Tenderness ___ Groin: Size ___ Tenderness ___ Other: Size ___ Tenderness ___
<b>Gastrointestinal</b> Abdomen:(Organs) Bladder/Kidney  Hernia: Liver and/or spleen:  Stool Specimen:	      	<b>Comprehensive level requires documentation of all elements</b> Mass: ___ Size: ___ Shape: ___ Consistency: ___ Tenderness: RUQ ___ LUQ ___ LLQ ___ RLQ ___ Rigidity: ___ Direct: ___ Rebound: ___ Other: _____ Inguinal: ___ RT: ___ LT Femoral: ___ LT Ventral: ___ Liver: Size ___ Tender ___ Mass ___ Spleen: Size ___ Tender ___ Mass ___ Not indicated _____ Collected _____

**IMPRESSION:**

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**RECOMMENDATIONS:**

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**PERSONAL & SOCIAL HISTORY:**

Birthplace: \_\_\_\_\_ Married: Yes \_\_\_\_\_ No \_\_\_\_\_ # of Children: \_\_\_\_\_

Occupation (prior to retirement) \_\_\_\_\_

SMOKING	ALCOHOL	COFFEE	ASPIRIN
Packs/day _____ # of years _____ Year stopped _____ Pipe Cigar Chew	Never _____ Occasional _____ Moderate _____ Heavy _____ Alcohol Problem: Y N	Cups/day _____	Tabs/day _____

**FAMILY HISTORY:**

Do you have family history of any of the following?

TB \_\_\_\_\_ Diabetes \_\_\_\_\_ Cancer \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Heart or Kidney Disease \_\_\_\_\_ Bleeding disorder \_\_\_\_\_

List any personal injuries, hospitalizations, or surgeries and when they occurred:

Illness or Surgery

Date

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Are you on any medications? Yes \_\_\_\_\_ No \_\_\_\_\_ List all: \_\_\_\_\_

Do you have any allergies? Yes \_\_\_\_\_ No \_\_\_\_\_ List all: \_\_\_\_\_

**Males only:** Do you have a family history of prostate cancer? Yes \_\_\_\_\_ No \_\_\_\_\_

**Females only-Ob/Gyn:**

Have you ever had any disorder of menstruation, pregnancy, breasts or female organs? \_\_\_\_\_

# of pregnancies \_\_\_\_\_ Vaginal deliveries \_\_\_\_\_ C-Section \_\_\_\_\_

Miscarriages \_\_\_\_\_ Date of last period \_\_\_\_\_ Length \_\_\_\_\_ days, how often \_\_\_\_\_

Recent Pap Smear (cancer test of cervix)? \_\_\_\_\_

**FOR OFFICE USE ONLY:**

Patient resides with whom, i.e. help at home? \_\_\_\_\_

HOSPITALIZATIONS

SURGERIES

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Has patient ever received any blood products? YES NO

**PATIENT HISTORY:**

Have you ever been treated for, or ever had any of the following?

Check the box Yes or No. Please explain any "Yes" answers.

	YES	NO	FOR OFFICE USE ONLY
<b>Constitutional Symptoms</b>			
Fever/chills			
Headache			
<b>Eyes</b>			
Blurred or double vision			
Pain			
<b>Allergic/Immunologic</b>			
Hay Fever/Shellfish/Iodine			
Drug allergies			
<b>Neurological</b>			
Tremors/stroke/numbness tingling			
Fainting/dizzy spells			
<b>Endocrine</b>			
Excessive thirst/diabetes/thyroid			
Too hot or cold/tired/sluggish			
<b>Gastrointestinal</b>			
Abdominal pain/nausea/vomiting			
Indigestion/heartburn/ulcer/intestinal bleeding			
<b>Cardiovascular</b>			
Chest pain/heart attack			
High blood pressure			
<b>Integumentary</b>			
Skin rash/boils/persistent itch			
<b>Musculoskeletal</b>			
Joint/neck/back pain			
<b>Ear, Nose, Throat, Mouth</b>			
Ear infection/sore throat/sinus problems			
<b>Genitourinary</b>			
Erectile dysfunction			
Urine retention/painful urination			
Frequent urination/incomplete voiding			
Urgency/dribbling			
<b>Respiratory</b>			
Wheezing/shortness of breath			
Bronchitis/pleurisy/asthma/emphysema			
Frequent cough/cough up blood			
<b>Hematologic/Lymphatic</b>			
Swollen glands			
Blood clotting problems			
<b>Psychologic</b>			
Are you generally satisfied with your life?			
Do you feel severely depressed?			
Have you considered suicide?			