

MRN: _____

Date: _____

Patient Name: _____

Date of Birth: ____/____/____ Age: ____

Marital Status: Married Single Widowed Divorced

Occupation (current or former): _____

CHIEF COMPLAINT:

What is the main reason for your visit today? (Please describe in detail)

HISTORY OF PRESENT ILLNESS:

<p>Location of Problem:</p> <p><input type="checkbox"/> Abdomen <input type="checkbox"/> Back <input type="checkbox"/> Genitals</p> <p><input type="checkbox"/> Other: _____</p>	<p>How long does the problem last?</p> <p><input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 day <input type="checkbox"/> Always there</p> <p><input type="checkbox"/> Other: _____</p>
<p>On a scale of 1-10, with 10 being the most severe, circle the number that best describes your problem:</p> <p>1 2 3 4 5 6 7 8 9 10</p>	<p>Is there anything else occurring at the same time?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain: _____</p> <p><input type="checkbox"/> Nausea <input type="checkbox"/> Rash <input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Other: _____</p>
<p>When did you first notice the problem?</p> <p><input type="checkbox"/> 2 days ago <input type="checkbox"/> 1 weeks ago <input type="checkbox"/> 1 month ago</p> <p><input type="checkbox"/> Other: _____</p>	<p>Is the problem constant or variable?</p> <p><input type="checkbox"/> Dull, then sharp <input type="checkbox"/> Sharp, then leaves</p> <p><input type="checkbox"/> Always there</p> <p><input type="checkbox"/> Other: _____</p>
	<p>Does the problem interfere with your normal function?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, explain: _____</p> <p>_____</p> <p>_____</p>

Physician Use Only (Comments and Notes)

MRN: _____

Date: _____

Patient Name: _____ Date of Birth: ___/___/_____ Age: _____
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MY MAIN PROBLEMS ARE:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> High PSA | <input type="checkbox"/> Bladder Infection |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Prostate Infection | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Bladder Cancer |
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Overactive Bladder | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Lump in Testicle | <input type="checkbox"/> Other: _____ | | |

ALLERGIES:

- | | | | | |
|---------------------------------------|------------------------------|--------------------------------|--------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> PCN | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Cipro | <input type="checkbox"/> Iodine/Contract |
| <input type="checkbox"/> Other: _____ | | | | |

MEDICATIONS: (PLEASE LIST ALL CURRENT MEDICATIONS)

SURGICAL HISTORY:

- | | | | | |
|---------------------------------------|---|--|--|--|
| <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Back/Hip/Knee | <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Kidney Stone Surgery | <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Prostate Biopsy | <input type="checkbox"/> Prostate Seed |
| <input type="checkbox"/> No Changes | <input type="checkbox"/> Other: _____ | | | |

MEDICAL HISTORY:

- | | | | | |
|--|-----------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> No Changes | <input type="checkbox"/> Hernia | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Stroke |
| Cancer: <input type="checkbox"/> Prostate | <input type="checkbox"/> Kidney | <input type="checkbox"/> Testis | <input type="checkbox"/> Other: _____ | |

FAMILY HISTORY:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Kidney Cancer | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Prostate Cancer |
|--|--|--|--|

MY SYMPTOMS ARE:

- | | | | |
|---------------------------|--|---|--|
| General/Constitutional | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Chills |
| Eyes | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Cataracts |
| Ears, Nose, Mouth, Throat | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Nasal Stuffiness | <input type="checkbox"/> Sore Throat |
| Cardiovascular | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Irregular Heartbeat |
| Respiratory | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Chronic Cough |
| Gastrointestinal | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Change in Bowels |
| Genitourinary | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine |
| Musculoskeletal | <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Chronic Neck Pain | <input type="checkbox"/> Sore Muscles |
| Integumentary/Skin | <input type="checkbox"/> Rash | <input type="checkbox"/> Persistent Itching | <input type="checkbox"/> Skin Cancer History |
| Neurologic | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Dizziness |
| Hematologic/Lymphatic | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Transfusion History |

URINARY SYMPTOMS ARE:

- | | | | | |
|--|---|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Incomplete Emptying | <input type="checkbox"/> Frequency | <input type="checkbox"/> Intermittency | <input type="checkbox"/> Straining | <input type="checkbox"/> Weak Stream |
| <input type="checkbox"/> Testicle Pain | <input type="checkbox"/> Pain in Side R/L | <input type="checkbox"/> Urinating at Night # _____ | | |

Lamia L. Gabal-Shehab MD Inc. Patient Signature: _____ Date: _____