arizona institute
of urology

TODAY'S DATE____/____/_____ DATE OF BIRTH ____/____/_____

LAST NAME_____FIRST NAME_____MIDDLE INITIAL_____

Chief Complaint

What is the main reason for your visit today? (Describe in Detail)

_____

_____

Have you had any x-rays or other testing for this condition? If so where and when?_____

Have you ever seen another urologist for this condition? If so whom and when? _____

History of Present Illness

Location of the problem
Abdomen **Back** **Groin**
Other_____

On a Scale of 1-10, with 10 being the most severe, circle The number that best describes the problem
1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

_____

Does anything help or make the problem worse?

_____

_____

How long does the problem last?

_____

Is anything else occurring at the same time?
Nausea/Vomiting **Pain** **Urinary Difficulties**
Other_____

Is the problem constant or variable?
Dull then Sharp Very Sharp then leaves Always there

_____

Does the problem interfere with your normal functions?
YES NO If yes, please explain._____

_____

Past Medical History

MEDICAL	YES	NO	MEDICAL (Cont)	YES	NO	BLADDER	YES	NO
Anemia or Sickle Cell Disease			High Blood Pressure			Bladder Infections		
Arthritis or Back Problems			Kidney Failure			Urethral Stricture		
Asthma			Neurological Disease			Problems with fertility		
Bleeding Tendencies			Pacemaker or Defribrilator			Leak urine with cough, sneeze or lifting		
Blood Transfusions			Myocardial Infarction			Dribbling at the end of urination		
Clotting Problems			Peripheral Vascular Disease			Urinary Tract Infections		
Bronchitis, Pneumonia or TB			Seizure or Epilepsy			Leak Urine, Unable to get to bathroom		
Emphysema/COPD			Stomach Ulcers			Blood in your urine		
Cancer			Stroke or Mini Stroke			**FEMALE**		
Chest Pain			Thyroid Abnormalities			Still having regular menstrual periods?		
Depression			Other (explain below)			Date of last period____/____/_____		
Diabetes			**PROSTATE**			Have you ever been pregnant?		
Elevated Cholesterol			Prostate Infections			Number of pregnancies _____		
GERD			Enlarged Prostate			Number of live born children_____		
HIV Infections/AIDS			**KIDNEY**			Number of miscarriages_____		
Heart Attack or Heart failure			Kidney Disease			Number of abortions _____		
Heart Murmur requiring antibiotics			Kidney Infections			Types of births (circle one)		
Heart Rhythm Abnormality			Kidney Stones			Vaginal C-Section # of C-sections		
Hepatitis, Liver Disease or Cirrhosis			Kidney failure			Were there any surgical complications?		

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Other

_____

_____

Past Surgeries: If none check here ☐

Operation Reason Hospital/Surgeon Date

Current Medications: If none check here ☐ List Attached ☐

Name Reason Dosage How Long?

Do you take Aspirin? Yes ☐ No ☐ Do you take any blood thinners? Yes ☐ No ☐

Allergies: If none check here ☐ If allergic to Iodine or X-ray dye check here ☐

Medication Foods Other Reaction

Review of Systems

Are you **currently** experiencing any of the following?

CONSTITUTIONAL	YES	NO	GASTROINTESTINAL	YES	NO	SKIN	YES	NO
Recent Weight Change			Change in Bowels			Rash		
Fever			Nausea/Vomiting			Persistent Itching		
Chills			Abdominal Pain			Change in Skin Color		
EYES			Reflux/Heartburn			**NEUROLOGICAL**		
Blurred Vision			**GENITOURINARY**			Dizziness		
Double Vision			Frequency			Numbness		
Glaucoma			Painful Urination			Tingling		
ENT			Blood in urine			Tremors		
Hearing Loss			Incontinence			Memory Loss/Dementia		
Sinus Problems			Flank Pain			**PSYCHIATRIC**		
Nose Bleeds			Sexual Difficulty			Depression		
Sore Throat			Testicle Pain			Anxiety		
CARDIOVASCULAR			Vaginal Discharge			**ENDOCRINE**		
Chest Pains			**MUSCULOSKELETAL**			Excessive Thirst or Urination		
Irregular Heartbeat			Joint Pain			Heat or Cold Intolerance		
Swollen Ankles			Joint Swelling			**HEMATOLOGICAL**		
RESPIRATORY			Weakness of Muscles or Joints			Easily Bruise or Bleed		
Chronic Cough			Muscle Pain or Cramps			Swollen Glands		
Shortness of Breath			Back Pain					

Family History

Does anyone related to you have a history of:

Prostate Cancer YES NO Relationship:_____

Kidney Disease YES NO Relationship:_____

Kidney Stones YES NO Relationship:_____

Cancer YES NO Relationship:_____

Anesthetic Problems YES NO Relationship:_____

Social History

Marital Status Married Single Divorced Widowed Separated Other

Do you smoke? YES NO How much_____ Did you smoke previously? YES NO How much_____

Do you drink Alcohol? YES NO How much_____ NOT ANYMORE NEVER DRANK

Do you drink Caffeine? YES NO How much daily ____0____1____2____3____4+ ____Coffee ___Tea _____Soda

History of alcohol/substance abuse? YES NO If yes, to what?_____

Hispanic or Latino? YES NO PRIMARY LANGUAGE_____

Race White Black or African American American Indian Alaska Native Eskimo
Hispanic or Latino Asian Native Hawaiian/Pacific Islander Unknown

Occupation Current: _____ Previous: _____