

UROLOGIC EVALUATION FORM

NAME _____ **BIRTH DATE** _____ **AGE** _____

Why are you seeking a urological evaluation? _____

To whom would you like us to send a report? _____

SOCIAL HISTORY

Do you / have you ever smoked? _____ How many packs per week? _____

How many years? _____ Have you stopped? _____

Alcohol intake? _____ How much alcohol per week? _____

Do you drink coffee/tea? _____ cups/day. Do you take any nonprescription drugs? _____

What is your occupation? _____

Mother's Age _____ Living _____ Deceased _____ Age at time of death _____

Father's Age _____ Living _____ Deceased _____ Age at time of death _____

of Sisters _____ Ages _____ Living _____ Deceased _____ Age at time of death _____

of Brothers _____ Ages _____ Living _____ Deceased _____ Age at time of death _____

of Daughters _____ Ages _____ Living _____ Deceased _____ Age at time of death _____

of Sons _____ Ages _____ Living _____ Deceased _____ Age at time of death _____

FAMILY HISTORY

	Yes	No
Are there any diseases that run in your family?	_____	_____
High Blood Pressure	_____	_____
Heart Disease	_____	_____
Colon Cancer	_____	_____
Prostate Cancer	_____	_____
Breast Cancer	_____	_____
Diabetes	_____	_____
Thyroid Disease	_____	_____

PERSONAL MEDICAL HISTORY

REVIEW OF SYSTEMS - CARDIOVASCULAR

	Yes	No
Do you have:	_____	_____
Angina (chest pain)	_____	_____
Palpitations	_____	_____
Heart Murmur	_____	_____

UROLOGY

Do you have:	Yes	No
Pain with urination	_____	_____
Blood in urine	_____	_____
Inability to control urine	_____	_____
Impotence	_____	_____
Need to urinate during the night	_____	_____
If yes, how many times?	_____	_____

PULMONARY

Do you have:	Yes	No
Shortness of breath	_____	_____
Do you need to sleep with your head up to breath at night?	_____	_____
Chronic Cough	_____	_____
Coughing up blood	_____	_____

GASTROINTESTINAL

Do you have:	Yes	No
Nausea	_____	_____
Vomiting	_____	_____
Diarrhea	_____	_____
Constipation	_____	_____
Change in bowel habits	_____	_____
Blood in stool	_____	_____

MUSCULOSKELETAL

Do you have:	Yes	No
Chronic back pain	_____	_____
Muscle aches	_____	_____
Arthritis	_____	_____

VASCULAR

Do you have:	Yes	No
Leg swelling	_____	_____
Foot ulcers	_____	_____
Pain in legs when walking or at rest	_____	_____
Bruising or bleeding	_____	_____

Other _____

PAST MEDICAL CONDITIONS

Yes

No

Are you allergic to any medications?

Medication _____

Reaction _____

Have you had any surgeries?

Yes _____

No _____

Operation _____

Date _____

Do you have any of the following medical problems?

Yes

No

High Blood Pressure

Heart Disease

Liver or Kidney Disease

Diabetes

Cancer

If yes, what type? _____

Other _____

Last menstrual period; _____

What medications do you take? _____

Date _____

Signature _____