SUMMIT
UROLOGY GROUP

Your Name: _____ Age: _____ Date of Birth _____/_____/_____

Referring Physician _____ Family Physician _____

Pharmacy _____ Phone: _____ Address _____

Your occupation _____ Retired? Yes No

This information is now required by the Federal Government
Primary Language _____ Race _____ Ethnicity _____

CHIEF COMPLAINT
What is the main reason for your visit today to the Urologist? _____
_____
_____
_____

List of all your current prescribed and over the counter medications:
(Please include Aspirin, Vitamins, Supplements, Sinus/allergy medications, etc.)

Drug Name & Dose _____ Drug Name & Dose _____

Drug Name & Dose _____ Drug Name & Dose _____

Drug Name & Dose _____ Drug Name & Dose _____

Are you ALLERGIC to any medications? Yes No
If yes, Please list the medications you are allergic to:_____
_____

LIST ALL SURGERIES/DATES

Surgery: _____ Date: _____ Surgery: _____ Date: _____

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Surgery: _____ Date: _____ Surgery: _____ Date: _____

Surgery: _____ Date: _____ Surgery: _____ Date: _____

MEDICAL HISTORY (circle the appropriate response in each column)

Do You Have a History of:				**Does your family have a history of:**			**Relationship to Patient**
Diabetes	Yes	No		Diabetes	Yes	No	_____
Heart Disease	Yes	No		Heart Disease	Yes	No	_____
Cancer	Yes	No	Type _____	Prostate Cancer	Yes	No	_____
High Blood Pressure	Yes	No		Bladder Cancer	Yes	No	_____
Kidney Stones	Yes	No		Kidney Cancer	Yes	No	_____
Stroke	Yes	No		Circulation Problems	Yes	No	_____
Bleeding Disorder	Yes	No	Type _____	Father Living?	Yes	No	
Breathing Problem	Yes	No	Type_____	Mother Living?	Yes	No	

Other Medical History:_____
_____

Cause of Death (Father) _____
Cause of Death (Mother) _____

Marital Status: (circle) Married Single Widowed
Number of children? _____

Have you ever smoked? (circle) Yes No
If yes, how long have you smoked? _____
If yes, how long ago did you quit? _____

How many caffeine drinks do you consume daily?
1 2 3 4+

Do you drink alcohol? Yes No longer Never
If yes, do you drink: Daily Weekly Social

Review of Body Systems

Please identify if you <u>currently</u> have problems related to the following systems:

Constitutional Symptoms:
Fever Yes No
Chills Yes No

Gastrointestinal Symptoms:
Abdominal Pain Yes No
Nausea/Vomiting Yes No
Indigestion Yes No

Cardiovascular Symptoms:
Chest Pain Yes No
Hypertension Yes No
Heart Attack Yes No
High Cholesterol Yes No
Pacemaker or Valve Yes No

Integumentary Symptoms:
Skin Rash Yes No
Persistent Itch Yes No
Boils Yes No

Endocrine Symptoms:
Unexplained Weight Loss Yes No
Excessive Thirst Yes No
Hot/Cold Spells Yes No

Respiratory Symptoms:
Wheezing Yes No
Frequent Cough Yes No
Shortness of Breath Yes No

Hematologic/Lymphatic Symptoms:
Swollen Glands Yes No
Blood Clotting Problems Yes No

Genitourinary Symptoms:
Urine Retention Yes No
Painful Urination Yes No
Visible Blood in Urine Yes No
Urinary Frequency Yes No
Urinary Leakage Yes No

Neurological Symptoms:
Tremors Yes No
Difficulty Walking Yes No
History of Seizure Disorder Yes No

Musculoskeletal Symptoms:
Joint Pain Yes No
Neck Pain Yes No
Back Pain Yes No

Psychologic:
Do you have Anxiety? Yes No
Are you depressed? Yes No

Number of Pregnancies _____
Number of Vaginal Deliveries _____
Do you use Estrogen/Hormone Replacement? Yes No

Current PSA if known: _____ (Males Only)
Date drawn _____/_____/_____
Lab/Physician where sample was drawn
_____

Is there any additional information that you feel your physician should know?

_____

_____

Today's date ____/_____/_____