**Urology Associates, Ltd.**

**A Division of Arizona Urology Specialists, PLLC**

**PLEASE PRINT**

**Visit Date**: **Doctor**:

**Patient Name**:

**Age**: **Birth Date**: **Gender**: **Male**  **Female** **(please circle)**

**Address**:

**Home Phone**: **Work Phone**: **Cell Phone**:

**E-Mail address:**

**Language**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Race:** **(i.e. Caucasian/Hispanic/Asian)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity:** **(i.e., American/ Mexican/German):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for visit**:

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**PREFERRED PHARMACY:**

**\*\*Please note: We send medications electronically**

**Pharmacy Name**:

**Pharmacy Address**:

**Pharmacy Phone #**: **Pharmacy Fax #**:

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**OTHER PROVIDERS:**

**Referring Physician:**  **Phone Number:**

**Primary Care Physician:** **Phone Number:**

**Would you like a letter to be sent to any additional doctors?** Yes No

**If yes, please write down the name of the doctor and address:**

**ALLERGIES:**

|  |  |  |  |
| --- | --- | --- | --- |
| **CIRCLE if you are allergic to the following?** | **LIST ALLERGIES TO MEDICATION AND REACTION:** | | |
|  |  |  |
| **Iodine** |  |  |  |
| **Hibiclens** |  |  |  |
| **Lidocaine/Marcaine** |  |  |  |
| **Latex** |  |  |  |

**MEDICATIONS:**

**Have you taken aspirin-containing products on a regular basis?**  Yes No

**Have you taken steroid or cortisone-type drugs within the last year?**  Yes No

**Have you ever received a pneumonia vaccine**?  Yes No

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME OF DRUG/SUPPLEMENT** | **DOSAGE OF DRUG (mg)** | **HOW OFTEN (# times per day)** | **Date Started on medication** |
|  |  |  |  |
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**Past Medical History:**

**Do you have a history of high blood pressure  Yes No**

**Please place a check (√) in the appropriate box for each organ listed. Describe the problem and type of surgery.**

Yes No if surgery performed Please provide details

Please, check box.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Cardiovascular (Heart/circulatory, aneurysms) |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| Cancer |  |  |  |  |
| Pulmonary (Lungs, wheezing, cough,  Shortness of breath) |  |  |  |  |
| Gastrointestinal (Stomach/esophagus/ulcer/abdominal pain, nausea/vomiting) |  |  |  |  |
| Renal/Genitourinary(Kidneys/bladder)  (change in stream, blood in urine, urinary leakage) |  |  |  |  |
| Neurological (tremors, dizziness, numbness/tingling, stroke, seizures) |  |  |  |  |
| Endocrine (diabetes/thyroid/parathyroid) |  |  |  |  |
| Hematologic (swollen glands, blood clotting, bruising) |  |  |  |  |
| Musculoskeletal/Connective Tissue  (muscle weakness, joint pain, sciatica, muscle pain) |  |  |  |  |
| Allergy/Immunology/Dermatology  (Skin rash, boils, persistent itch) |  |  |  |  |
| Psychiatric (depression, anxiety) |  |  |  |  |
| HIV/ Hepatitis B/ Hepatitis C |  |  |  |  |
| Any other medical Conditions? |  |  |  |  |

Have you ever been hospitalized? \_\_\_\_\_\_\_ If yes, which reason(s) and which date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SURGICAL HISTORY:**

Have you had any surgeries? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ if yes, please specify which surgery and which date the surgery was performed.

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**FAMILY HISTORY:**

Any family history of urological conditions or urological cancer? If yes, which and whom.

Father:  Alive (Age ) Any Known Medical Conditions? If yes which-

Deceased (Age )  Unknown Cause of Death:   Unknown

Mother:  Alive (Age ) Any Known Medical Conditions? If yes which ones-

Deceased (Age )  Unknown Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unknown

Family history of any illnesses or cancer, etc? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number Approximate Number Approximate Cause(s) of

Alive Age(s) Deceased Age(s) at Death Death/Medical conditions

Brothers: Unknown

Sisters: Unknown

Sons: Unknown

Daughters: Unknown

**SOCIAL HISTORY**

**OCCUPATION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (PLEASE CIRCLE) MARRIED SINGLE

DIVORCED WIDOWED

Current Spouse

Information:  Not applicable Alive (Age )  Deceased

Health problems or cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tobacco/Alcohol/Supplements**

CURRENTLY PREVIOUSLY TYPE/AMOUNT HOW LONG IF STOPPED,

USE USED FREQUENCY (YEARS) WHEN? (YR)

**TOBACCO:** Y N Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALCOHOL:** Y N Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CAFFEINE:** Y N Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OVER THE**

**COUNTER**

**SUPPLEMENTS:** Y N Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ILLEGAL DRUGS:** Y N Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS:**

Have you experienced any of the following problems recently?Please place a check (√) in the appropriate box.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CONSTITUTIONAL SYMPTOMS** | **Yes** | **No** | **RESPIRATORY** | **Yes** | **No** | **INTEGUMENTARY** | **Yes** | **No** |
| Fever |  |  | Wheezing |  |  | Skin rash |  |  |
| Chills |  |  | Frequent cough |  |  | Boils |  |  |
| Headaches |  |  | Shortness of breath |  |  | Persistent rash |  |  |
|  |  |  |  |  |  |  |  |  |
| **EYES/HEARING** |  |  | **GASTROINTESTINAL** |  |  | **NEUROLOGICAL** |  |  |
| Blurry vision |  |  | Hepatitis |  |  | Dizziness |  |  |
| Glaucoma |  |  | Ulcer/reflux |  |  | Migraine |  |  |
| Loss of hearing/Ringing |  |  | Constipation |  |  | Multiple sclerosis |  |  |
|  |  |  |  |  |  |  |  |  |
| **EAR/NOSE/THROAT/MOUTH** |  |  | **GENITOURINARY** |  |  | **HEMATOLOGIC/LYMPMATIC** |  |  |
| Ear infection |  |  | Kidney Failure |  |  | Lymph node swelling |  |  |
| Sore throat |  |  | Kidney Stones |  |  | Bleeding disorder |  |  |
| Difficulty swallowing |  |  | Urinary tract infection |  |  | Immune disorder (HIV) |  |  |
|  |  |  | Erectile dysfunction **(males)** |  |  |  |  |  |
| **CARDIOVASCULAR** |  |  | **MUSCULOSKELETAL** |  |  | **ENDOCRINE** |  |  |
| Chest pain |  |  | Back pain/surgery |  |  | Diabetes |  |  |
| High blood pressure |  |  | Muscle disorder |  |  | Thyroid disease |  |  |
| Varicose veins |  |  | Joint disorder |  |  | Parathyroid disease |  |  |
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**FEMALE PATIENTS ONLY**

|  |
| --- |
| Might you be pregnant at this time? Y N  Date of onset of your last menstrual period: Month: \_ Day: Year: \_\_\_\_\_\_\_\_\_\_  Number of Pregnancies: Live Births: Vaginal Deliveries:  Miscarriages/Abortion:\_\_\_\_\_\_\_\_\_ |

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**AUA SYMPTOM INDEX (MALE PATIENTS ONLY)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Circle ONE number in each column that best**  **answers the following questions:** | **Not at**  **all** | **Less**  **than**  **1 times**  **in 5** | **Less**  **than**  **half the**  **time** | **About**  **half**  **the**  **time** | **More**  **than**  **half the**  **time** | **Almost**  **always** |
| 1. 1. **INCOMPLETE EMPTYING** 2. Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| 1. 2. **FREQUENCY**   Over the past month or so, how often have you had to urinate again t less than 2 hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| 3. **INTERMITTENCY**  Over the past month or so, how often have you found you  stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 |
| 4. **URGENCY**   1. Over the past month or so, how often have you found it   difficult to postpone urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| 5. **WEAK STREAM**  Over the past month or so, how often have you had a weak  urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 |
| 6. **STRAINING**  Over the past month or so, how often have you had to  push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **NOCTURIA**  On average, how many times do you most typically get up to urinate from the time you went to bed at night until the time you get up in the morning? | 0 | 1 | 2 | 3 | 4 | 5 |

|  |
| --- |
|  |

**Grand Total =**

**Quality of Life Bother Score (MALE PATIENTS ONLY)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Delighted | Pleased | Mostly  Satisfied | Mixed (about equally satisfied and dissatisfied) | Mostly  dissatisfied | Unhappy | Terrible |
| If you had to spend the rest of your life urinating just the way it is now, how would you feel about that? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |