**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 |   |   |
|   |   |   |   |   |   |  |   |   |
|   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |

**FEMALE PATIENTS ONLY**

|  |
| --- |
| Might you be pregnant at this time? Y NDate 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 youstopped 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 weakurinary stream? | 0 | 1 | 2 | 3 | 4 | 5 |
| 6. **STRAINING**Over the past month or so, how often have you had topush 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 | MostlySatisfied | 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 |