UROLOGIC CLINICS OF NORTH ALABAMA
First visit questionnaire
CONFIDENTIAL
Please fill both sides of the two sheets as completely as possible
If you have any questions or need any clarification, please ask the nurse

Name:_________________________________**Age**:_____yrs **Sex**: M / F

Race: _______**Marital Status**:_______________**Occupation**________________

Physician requesting Consult:______________________**Today's Date:**________

What are your chief complaints:

1_____________________________________For how long_____________
Severity (0-10) ___________What brought it on?________________
Anything makes it better?_____________, worse?________________
2_____________________________________ For how long ____________
Severity (0-10) ___________What brought it on?________________
Anything makes it better?_____________, worse?________________
3_____________________________________ For how long ____________

Urologic History: *(Please circle one)*

1. Do you have any difficulty voiding? Yes / No

   If yes:Hesitancy____, Straining____, Incomplete emptying_____

2. Do you have any symptoms of overactive bladder? Yes / No

   If yes: Daytime frequency every___hour(s)

   Night time ____times/night, urgency: yes/no

3. Do you leak urine? Yes / No
4. Do you have a Bladder/Kidney infection? Yes / No
5. Do you have any pain? Yes / No
6. Do you have erectile dysfunction / Impotence Yes / No
7. Do you have a lack of desire for sex Yes /No
7. Do you have blood in the urine? Yes / No

   If yes: initial / terminal / total; gross / micro; painful / painless

8. Do you *have / ever had* kidney stones Yes / No
9. Do you have any genital lesions / STDs Yes / No

   If yes, describe___________________________________

Reviewed
____
Doctor's Initials

Review of Systems: Do you now or have you had problems related to the following systems. Circle yes or no. If yes please explain in the space provided.

Constitutional
- Fever Y N
- Chills Y N
- Headaches Y N
- Other____________________________

Eyes
- Blurred vision Y N
- Double vision Y N
- Pain Y N
- Other____________________________

Ear/ Nose/ Throat/ Mouth
- Ear infection Y N
- Sore throat Y N
- Sinus problems Y N
- Hearing problems Y N
- Other____________________________

Cardiovascular
- Chest Pain Y N
- High Blood Pressure Y N
- Varicose Veins Y N
- Heart Disease Y N
- Heart Attack Y N
- Other____________________________

Neurological
- Tremors Y N
- Dizzy Spells Y N
- Numbness/Tingling Y N
- Stroke Y N
- Other____________________________

Endocrine
- Excessive thirst Y N
- Too hot/cold Y N
- Tired/sluggish Y N
- Other____________________________

Infection
- Mumps Y N
- Tuberculosis Y N
- AIDS/ HIV Y N
- Other____________________________

Integumentary/Skin
- Skin Rash Y N
- Boils Y N
- Persistent itch Y N
- Other____________________________

Allergy/Immunologic
- Hay Fever Y N
- Allergies Y N
- AutoImmune diseases Y N
- Other____________________________

Respiratory
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Hoarseness Y N
- Other____________________________

Gastrointestinal
- Abdominal Pain Y N
- Nausea/vomiting Y N
- Indigestion/Heartburn Y N
- Diarrhoea Y N
- Constipation Y N
- Other____________________________

MusculoSkeletal
- Joint Pain Y N
- Neck Pain Y N
- Back Pain Y N
- Muscle weakness Y N
- Other____________________________

Hematology/ Oncology
- Swollen Glands Y N
- Bleeding Disorders Y N
- Cancer Y N
- Other____________________________

Psychologic
- Depression Y N
- Suicidal Y N
- Bipolar Y N
- Other____________________________

Nurses Notes:
____
____
____
____
____

Nurse's Signature______________________________Date_______________

Reviewed

______
Doctor's Initials

Medications: Please list all the medications you are on, *including over the counter and herbal medications.* None_________

Drug	Dosage MgsXtimes/day	Reason/condition for which you are taking it?

Drug Allergies: ______None

Name of drug	Reaction		Name of drug	Reaction

Surgical History: ______None

Year	Operation	Complications

Have you had a **blood transfusion?** Yes / No, If yes date(s)_______________
Reason_______________________

Any hospital admissions not listed above? _____None

Year	Reason	Complication

Reviewed

Doctor's Initials

Ob history: (Female patient only) *(Please circle one)*

1. Are you pregnant?___________Last menstrual period?_________

2. # of pregnancies_____, # of deliveries_____, # of miscarriages______

3. Type of delivery: Spontaneous vaginal/ Forceps/ Caesarian Section

4. Menopause Yes/ No. Year______

Personal History: *(Please circle one)*

1. Do you smoke? Yes / No If yes, # of pkts____# of yrs____
   Did you ever smoke? Yes/No If yes Quit when?__________
   Do you chew tobacco? Yes/No; if yes quantity ___________

2. Do you drink alcohol? Yes/ No If yes, amount_____# of yrs____

3. Do you use recreational drugs? Yes / No, If yes what__________

4. Any dietary excesses? Yes/No If yes what_____________________

Family History: Do *you or your family members* suffer from

Condition	You Y/N	Family Y/N	Relation	Notes
Mental problems(name)				
Bleeding Disorders				
Thyroid disease				
Diabetes				
High Blood Pressure				
Asthma				
Kidney disease				
Kidney stone				
Bladder Cancer				
Prostate Cancer				
Other cancer (name)				
Stroke				
Heart Problems (name)				
Other (name)				
Other (name)				

Any additional information:____

The above information is true and accurate.

Patient/Guardian's Signature______________________________Dated:________________

I have reviewed the above information with the patient

Doctors Signature______________________________________Dated________________

Level of History	Prob Focussed: CC + 1 HPI	Exp. Prob. Focussed CC + 1 HPI + 1 ROS	Detailed: CC+4 HPI+2 ROS+1PFSH	Comprehensive: CC+4HPI+10ROS+3PFSH