

Date: _____

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Race: W B Other _____ Ethnicity: Hispanic & Latino Other _____
 Language: English Spanish Italian Chinese Korean Other _____
 * The information above is requested as part of a U.S. Government initiative, not The Bryn Mawr Urology Group / division of MU.

My Main Problem(s) is/are:

- Leak Urine Blood in urine Dropped Bladder Bladder Pain
 Kidney Stones Bladder Cancer Overactive Bladder Interstitial Cystitis
 Bladder Infection Other _____

When did the problem begin: _____

My Other Medical Problem(s) is/are:

- Fever Weight Loss Chills
 Blurry Vision Double Vision Cataracts Glaucoma
 Hearing Loss Sore Throat Sinusitis Migraines
 Angina High Blood Pressure Chest Pains Irregular Heartbeat
 Problems with Heart Valves Rheumatic Fever
 Short of Breath Chronic Cough Wheezing Emphysema
 Abdominal Pain Nausea/Vomiting Bloody / Dark Stools Change in Bowels
 New Skin Lesion Changes in hair Changes in nails Breast Lumps
 Area of Numbness Weakness Stroke Difficulty Walking
 Loss of Bowel Control Depression Difficulty Sleeping Asthma
 Thyroid Condition Diabetes Immune Deficiency "Hay Fever"
 Anemia Enlarged lymph nodes Transfusion History Urine leakage
 Arthritis Chronic Back Pain Chronic Neck Pain Urinary Incontinence
 Blood in Urine Urinary tract infection Kidney Stones

Do you have Bleeding Tendencies (Easy bleeding / bruising)? Yes No

Allergies:

- None Penicillin Sulfa Cipro Iodine/contrast Shellfish
 Other _____

Medications:

- None Aspirin Plavix Coumadin Advil Fish Oil Vitamin E

Please list all of your other medications: _____

When was your last Flu Shot? _____ When was your last Pneumovax? _____

Surgical History:

- Heart Bypass Lithotripsy Gallbladder Appendectomy Cystoscopy
 Kidney Stone Surgery Back Hip Knee

Please list your other operations: _____

When was your last Colonoscopy? _____ Where: _____

