

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:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> High PSA | <input type="checkbox"/> Bladder Infection |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Prostate Infection | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Bladder Cancer |
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Overactive Bladder | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Lump in Testicle | <input type="checkbox"/> Other _____ | | |

When did the problem begin: _____

My Other Medical Problem(s) is/are:

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

- | | | | |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> Prostate Surgery | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Prostate Seeding | <input type="checkbox"/> Lithotripsy |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> Kidney Stone Surgery |
| <input type="checkbox"/> Prostate Biopsy | <input type="checkbox"/> Back | <input type="checkbox"/> Hip | <input type="checkbox"/> Knee |

Please list your other operations: _____

When was your last Colonoscopy? _____ Where: _____

Medical History:

- | | | | |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Strokes / Neurologic Disorder | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Exposure to TB |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Hernia | |
| <input type="checkbox"/> Other _____ | | | |

Family History:

- | | | |
|---------------------------------------|-----------------------------|---|
| Prostate Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes, whom? _____ |
| Kidney Stones | <input type="checkbox"/> No | <input type="checkbox"/> Yes, whom? _____ |
| Heart Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes, whom? _____ |
| <input type="checkbox"/> Other: _____ | | |

Social History:

- Married Single Divorced Widowed Separated Number of Children _____

- Do you smoke? **Yes** When did you start? _____ Packs Per Day _____
- Not Anymore** When did you quit? _____ Packs Per Day _____
- How long? _____
- Never Smoked**

- Do you drink alcohol? **Yes** How many drinks/day? _____
- Types of alcohol: Beer Liquor Wine
- Drinking Habits: Social Light Moderate
- Not Anymore** When did you quit drinking? _____
- How long did you drink? _____
- How many drinks per day? _____
- Never Drank**

How many caffeinated drinks do you have each day? _____

Have you had a Blood Transfusion? Yes No

Employment: Retired Occupation (Current or Previous) _____

Living Will Advance Directive

IS THERE ANY OTHER INFORMATION YOU FEEL IS IMPORTANT TO SHARE WITH US, NOT LISTED ABOVE? _____

I certify to the best of my knowledge that all of the information listed above is true and correct:

Patient's Signature: _____