

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  No  Yes, whom? \_\_\_\_\_
- Kidney Stones  No  Yes, whom? \_\_\_\_\_
- Heart Disease  No  Yes, whom? \_\_\_\_\_
- 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:** \_\_\_\_\_