Conway Urology, PA

Name _____ Date _____

Referring Doctor _____ Family Doctor_____

1. What concerns do you want to be sure to discuss at today's appointment?
   _____
2. What symptoms do you want your provider to be aware of?
   _____
   _____

3. What pharmacy do you use? _____
5. Please list all allergies (Drug, seasonal, pets, environmental, foods, etc)_____
_____

SOCIAL HISTORY

Marital Status:

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Life Partner

Dependants: Please indicate # of each, if applicable

Sons	Daughters	Stepchildren	Adopted
_____	_____	_____	_____

Occupation

___ Retired ____Laborer ____Truck Driver ____Clerk ___Administrative ___ Executive

___Professional ____Part Time ____None _____Other

Hobbies: (Please list)

_____

_____

Alcohol Consumption

_____ None _____Occasional/Social # of drinks per day _____

Tobacco per day

____ None _____# Packs/day #_____Cigarettes/day _____Smokeless tobacco

If you previously stopped smoking, when did you quit? _____

Recreational Drugs _____ None If yes, list_____

Caffeinated beverages: _____None _____Low _____ Moderate ____Excessive

Recent Foreign Travel _____ None ____Americas Other, please list_____

REVIEW OF SYSTEMS: Please check any symptoms/problems you are currently having

Constitutional
- ☐ Appetite changes
- ☐ Anorexia
- ☐ Aches and Pains
- ☐ Chills
- ☐ Easy Bruising
- ☐ Fever
- ☐ Fatigue
- ☐ Generalized Weakness
- ☐ Insomnia
- ☐ Night Sweats
- ☐ Sleep Apnea
- ☐ Swollen Glands
- ☐ Weight Gain
- ☐ Weight Loss

Eyes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Pain
- ☐ Worsening Eyesight

Allergic/Immunologic
- ☐ Animal Allergies
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Seasonal Allergies

Neurological
- ☐ Balance problems
- ☐ Disoriented
- ☐ Dizzy Spells
- ☐ Headache
- ☐ Lack of Alertness
- ☐ Leg or Arm Weakness
- ☐ Memory loss
- ☐ Numbness/tingling
- ☐ Stroke
- ☐ Speech problems
- ☐ Tremors

Endocrine
- ☐ Diabetes
- ☐ Excessive thirst
- ☐ Pituitary disease
- ☐ Thyroid disease
- ☐ Tired/sluggish
- ☐ Too hot/cold

Gastrointestinal
- ☐ Abdominal cramps
- ☐ Abdominal pain
- ☐ Acid reflux
- ☐ Bloody stools
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Flatulence
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion/heartburn
- ☐ Irregular bowel movements
- ☐ Nausea/vomiting
- ☐ Rectal bleeding
- ☐ Tarry stool

Cardiovascular
- ☐ Chest pain/angina
- ☐ Dyspnea on exertion
- ☐ Edema
- ☐ Heart attack
- ☐ Heart failure
- ☐ Heart Murmur
- ☐ High blood pressure
- ☐ Mitral valve prolapse
- ☐ Orthopnea
- ☐ Pain/cramps w/exercise
- ☐ Palpitations
- ☐ Skipped heart beats
- ☐ Swelling

Skin
- ☐ Acne
- ☐ Boils
- ☐ Changing moles
- ☐ Persistent itch
- ☐ Pigment change
- ☐ Skin rash

Musculoskeletal
- ☐ Arthritis
- ☐ Back pain
- ☐ Gout
- ☐ Joint pain
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Neck pain/stiffness

Ear/Nose/Throat
- ☐ Ear infection
- ☐ Sinus problems
- ☐ Sore throat

Genitourinary
- ☐ Back pain
- ☐ Bedwetting
- ☐ Blood in urine
- ☐ Dribbling
- ☐ Burning on urination
- ☐ Erection problems
- ☐ Flank pain
- ☐ Hematuria
- ☐ Hesitancy
- ☐ Kidney failure
- ☐ Kidney infections
- ☐ Kidney stones
- ☐ Leak after voiding
- ☐ Nocturia
- ☐ Nocturnal enuresis
- ☐ Not emptying
- ☐ Painful ejaculation
- ☐ Stranguria
- ☐ Stones, other
- ☐ Suprapubic pain

Genitourinary cont.
- ☐ Urgency
- ☐ Urinary frequency
- ☐ Urinary hesitancy
- ☐ Urinary incontinence
- ☐ Urinary tract infections
- ☐ Urine retention
- ☐ Urological cancer
- ☐ Urological surgery
- ☐ Vaginal bleeding
- ☐ Vaginal discharge/problems
- ☐ Weak stream

Respiratory
- ☐ Asthma
- ☐ Emphysema-bronchitis
- ☐ Environmental allergies
- ☐ Frequent cough
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Tuberculosis
- ☐ Wheezing

Hematological/Lymphatic
Swollen glands
- ☐ Blood clotting problem
- ☐ Bleeding problem
- ☐ Hepatitis
- ☐ HIV (Aids)
- ☐ Sickle Cell

Psychologic
- ☐ Anxiety
- ☐ Depressed
- ☐ Satisfied with life

Name _____

PAST MEDICAL HISTORY (Any diseases or conditions you have or have had

Cardiovascular

- ☐ Anemia
- ☐ Angina
- ☐ Aortic Aneurysm
- ☐ Aortic Regurgitation
- ☐ Aurotic Stenosis
- ☐ Arrythmia
- ☐ Atrial Fibriliation
- ☐ Bleeding Disorder
- ☐ Cardiomyopathy
- ☐ Cerebrovascular Disease
- ☐ Claudication
- ☐ Congenital Heart Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Endocarditis
- ☐ Enlarged Heart
- ☐ Heart Attack
- ☐ Heart Block
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Problem
- ☐ Hemophilia
- ☐ Hypertension well controlled
- ☐ Hypertension progressive
- ☐ Hypertension, severe
- ☐ Leukemia
- ☐ Mitral Insufficiency
- ☐ Mitral Stenosis
- ☐ Mitral Valve Prolapse
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Thrombophlebitis
- ☐ Varicose veins
- ☐ Ventricular Arrhythmia

Endocrine/Metabolic

- ☐ Diabetes, non-insulin
- ☐ Diabetes, insulin dependent
- ☐ Diabetes, uncontrolled
- ☐ Goiter
- ☐ Gout
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Impared Glucose Tolerance

General

- ☐ Allergies
- ☐ Electrical Injury
- ☐ Exposure to chemicals
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hypercholesterolemia

General, cont

- ☐ Hyperlipidemia
- ☐ Infectious Disease
- ☐ Lipid Disorder
- ☐ Malaise
- ☐ Obesity
- ☐ Paget's Disease
- ☐ PCKD
- ☐ PCO
- ☐ Raynaud's Syndrome
- ☐ Sleep Apnea

GI

- ☐ Cholecystitis
- ☐ Cholelithiasis
- ☐ Chronic Liver Disease
- ☐ Colitis
- ☐ Constipation
- ☐ Colon Condition
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ GERD
- ☐ Hemorrhoids
- ☐ Hepatic Failure
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ Inflammatory Bowel Dis
- ☐ Liver Disease
- ☐ Pancreatitis
- ☐ Peptic Ulcer (Duodenal)
- ☐ Rectal Fissure
- ☐ Stomach Ulcer
- ☐ Ulcerative Colitis

GU

- ☐ AIDS
- ☐ Bladder Outlet Obstruction
- ☐ Bladder Stone
- ☐ Bladder Infection
- ☐ Chronic Renal Disease
- ☐ Chronic Renal Failure
- ☐ Crossed Fused Ectopia
- ☐ Hematuria
- ☐ Impotence
- ☐ Interstitial Cystitis
- ☐ Irradiation Therapy
- ☐ Kidney Cancer
- ☐ Kidney Disease
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Libido Decreased
- ☐ Nephrolithiasis
- ☐ Nephrotic Syndrome
- ☐ Neurogenic Bladder
- ☐ Orchitis

GU cont

- ☐ Penile Discharge
- ☐ Orchitis
- ☐ Penile Discharge
- ☐ Polycystic Disease
- ☐ Prostate Cancer
- ☐ Radiation Exposure
- ☐ Recurrent UTI
- ☐ Renal Cell Cancer
- ☐ Renal Insufficiency
- ☐ Testicular cancer
- ☐ Transplant Recipient
- ☐ TCCA-Bladder
- ☐ TCCA-Ureter
- ☐ Undescended Testicle
- ☐ UTI
- ☐ Venereal Disease

GYN/OB

- ☐ Breast Cancer
- ☐ Endometriosis
- ☐ Menopause
- ☐ Menstrual Problems
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Uterine Fibroids

HEENT

- ☐ Blindness
- ☐ Cataracts
- ☐ Deviated Septum
- ☐ Deafness
- ☐ Ear Infections
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Menniere's
- ☐ Mumps
- ☐ Sinusitis
- ☐ Tinnitis
- ☐ Vertigo

Musculoskeletal

- ☐ Arthritis
- ☐ Back Pain
- ☐ Carpal Tunnel
- ☐ Claudication
- ☐ Fibromyalgia
- ☐ Mortons Neuroma

Neurologic/Physchological

- ☐ ADD
- ☐ ADHD
- ☐ Alcoholism
- ☐ Alzheimers
- ☐ Anxiety
- ☐ Bi-polar Disorder

Nero/Physch con't

- ☐ Chronic Fatigue
- ☐ Depression
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Herniated Disc
- ☐ Mental Illness
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Nervous Breakdown
- ☐ OCD
- ☐ Organic Brain Syndrome
- ☐ Parapalegia
- ☐ Parkinson's
- ☐ Polio
- ☐ Quadraplegia
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Spinal Cord Injury
- ☐ Stroke
- ☐ Suicide Attemps
- ☐ TIA

Respiratory

- ☐ Asthma
- ☐ Bronichitis
- ☐ Chronic Lung Disease
- ☐ COPD
- ☐ Emphysema
- ☐ Lung Disease
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Tuberculosis

Tumors/Malignancies

- ☐ Adenocarcinoma
- ☐ Basal Cell Carcinoma
- ☐ Brain Tumor
- ☐ Breast Cancer
- ☐ Hodgkins
- ☐ Laryngeal Cancer
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Melanoma
- ☐ Metastatic Cancer
- ☐ Pancreatic Cancer
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Renal Cell Carcinoma
- ☐ Skin Cancer
- ☐ Testicular Cancer
- ☐ TCCA Bladder
- ☐ TCCA Ureter

SURGICAL HISTORY

Please check if you <u>have had</u> any of the following surgeries and date of surgery (if possible):

Urologic
- ☐ Bladder Surgery
- ☐ Biopsy of the Prostate
- ☐ Brachytherapy
- ☐ Circumcision
- ☐ Contigen
- ☐ Cystoscopy
- ☐ Cystoscopy-Dilation
- ☐ Cystoscopy-Retrograde
- ☐ Cystoscopy-Stent
- ☐ Cysto-TUR Fulgueration
- ☐ Durasphere
- ☐ Epididymectomy
- ☐ ESWL
- ☐ Herniorrhaphy
- ☐ Hydrocelectomy
- ☐ Ileal conduit
- ☐ Indigo Laser Surgery
- ☐ Inguinal Herniorraphy
- ☐ Interstim
- ☐ Kidney Stone
- ☐ Laser Lithotripsy
- ☐ Meatotomy
- ☐ Needle Biopsy-Prostate
- ☐ Nephrectomy
- ☐ Nephrolithotomy
- ☐ Orchioectomy
- ☐ Orchiopexy
- ☐ Penile Implant
- ☐ Penectomy
- ☐ Penile Surgery
- ☐ Pyeloplasty
- ☐ Radical Prostatectomy

Urologic (cont)
- ☐ Renal Transplant
- ☐ Spermatocelectomy
- ☐ TUMT-Prostate
- ☐ TUMD-Prostate
- ☐ TURBT
- ☐ TUR-Prostate
- ☐ Ureteroscopy
- ☐ Variocelectomy
- ☐ VLAP

Cardiovascular
- ☐ Angioplasty
- ☐ Aortic Aneurysm Repair
- ☐ CABG
- ☐ Carotid Artery Surgery
- ☐ Heart Surgery
- ☐ Heart Surgery (Stents)
- ☐ Heart Transplant
- ☐ Pacemaker Insertion
- ☐ Vein Stripping

General
- ☐ Brain Surgery
- ☐ Laminectomy
- ☐ Lymphatic Node Dissection
- ☐ Parathyroidectomy
- ☐ Pilondial Cyst Incision
- ☐ Skin Grafting

GI
- ☐ Appendectomy
- ☐ Bariatric Surgery
- ☐ Bowel Resection

GI (Cont)
- ☐ Cholecystectomy
- ☐ Colon Resection
- ☐ EGD
- ☐ EGD/Dilation Esophagus
- ☐ Fissurectomy
- ☐ Gastric Surgery
- ☐ Hemorrhoidectomy
- ☐ Ileostomy
- ☐ Laparoscopy
- ☐ Liver Surgery
- ☐ Liver Transplant
- ☐ Lumpectomy of Breast
- ☐ Lysis Adhesions
- ☐ Nissen Fundoplication
- ☐ Splenectomy
- ☐ Stomach Surgery
- ☐ Umbilical Hernia
- ☐ Ventral Hernia Repair

GYN
- ☐ C-Section
- ☐ D & C
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Oophorectomy

HEENT
- ☐ Cataract Surgery
- ☐ Corneal Surgery
- ☐ Ear Surgery
- ☐ Eye Surgery
- ☐ Facial Surgery
- ☐ Mastoid Surgery
- ☐ Nasal Surgery
- ☐ PEG
- ☐ PE Tubes
- ☐ Septoplasty
- ☐ Sinus Surgery
- ☐ Tonsil Surgery
- ☐ Thyroid Surgery
- ☐ TMJ Surgery

Musculoskeletal
- ☐ Amputation
- ☐ Arthroscopic Knee
- ☐ Back
- ☐ Carpal Tunnel
- ☐ Cervical Spine
- ☐ Disc
- ☐ Foot
- ☐ Hand
- ☐ Hip
- ☐ Knee
- ☐ Leg
- ☐ Rotator cuff
- ☐ Shoulder

Respiratory
- ☐ Lung

Skin
- ☐ Basal Cell carcinoma
- ☐ Melanoma
- ☐ Squamous cell carcinoma

Other:_____

_____

FAMILY HISTORY

Please indicate which family member has/had any of the following (Mother, Father, Siblings, Grandparent, Aunt Uncle):

Arthritis _____ Leukemia _____

Bedwetting _____ Malignant Melanoma _____

Bladder Cancer _____ Multiple Sclerosis _____

Cancer (Site unknown)_____ Laryngeal Cancer_____

Crohn's Disease_____ Pancreatic Cancer_____

Depression _____ Prostate Cancer _____

Diabetes _____ Stroke _____

Gout _____ Thyroid Disease _____

Heart Attack _____ Tuberculosis _____

Hypertension _____ Kidney Disease _____

Other: _____

_____