

OREGON UROLOGY INSTITUTE

Better Options. Better Care.

Patient Medical Info

Full Name: _____ Date of Birth: _____

Reason for today's visit: _____

Height _____ Weight _____

Current Medications

Medication	Dose	How Often	Medication	Dose	How Often
Example: Atrovan	10 mg	1 a day			

Allergies to Medications (please circle) YES / NO If so, to what drug(s) and with what reaction(s):

Past Medical History (Please only if you have a history of any of the following):

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal Heart Rhythm | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Brain Tumor |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Cervical Cancer |
| <input type="checkbox"/> Asthma | | <input type="checkbox"/> Cirrhosis |

- Colon Cancer
- Congestive Heart Failure
- COPD
- Coronary Artery Disease
- Crohns/Ulcerative Colitis
- Dementia
- Depression
- Diabetes – Type 1 (juvenile)
- Diabetes – Type 2 (adult)
- Diverticulitis/Diverticulosis
- DVT/Blood Clots in Legs
- Endometriosis
- Fibromyalgia
- GERD
- Glaucoma
- Head/Neck Cancer
- Heart Attack
- Hepatitis
- High Blood Pressure
- High Cholesterol/Lipids
- Hypothyroidism
- Irritable Bowel Syndrome
- Leukemia
- Liver Disease

- Lung Cancer
 - Lupus
 - Lymphoma
 - Multiple Sclerosis
 - Myeloma
 - Neurologic Disorder
 - Osteoarthritis
 - Osteoporosis
 - Ovarian Cancer
 - Pancreatitis
 - Parkinsons Disease
 - Peripheral Vascular Disease
 - Pneumonia
 - Pulmonary Emboli
 - Rheumatoid Arthritis
 - Seizure Disorder
 - Sleep Apnea
 - Spinal Cord Injury
 - Stroke
 - Thyroid Cancer
 - Ulcer Disease/GI Bleed
 - Uterine Cancer
 - Valvular Heart Disease
- Past Urologic History:**

- Bladder Cancer
- Dialysis
- Incontinence
- Infertility
- Kidney Cancer
- Kidney Failure
- Kidney Stone(s)
- Prostate Cancer
- Pyelonephritis
- Renal Failure
- Urinary Tract Infection

NONE OF THE ABOVE APPLY

Other Issues Not Listed:

Past Surgical History (Please only if you have had of any of the following):

- | | | |
|--|--|---|
| <input type="checkbox"/> Abdominoplasty/
Tummy Tuck | <input type="checkbox"/> Carotid Endarterectomy | <input type="checkbox"/> Hip Replacement |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Aneurysm Repair | <input type="checkbox"/> Carotid Artery Surgery | <input type="checkbox"/> Hysterectomy with
Removal
of Ovaries |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Cataract | <input type="checkbox"/> Knee Replacement |
| <input type="checkbox"/> Antireflux Surgery | <input type="checkbox"/> Colon Surgery | <input type="checkbox"/> Laminectomy |
| <input type="checkbox"/> Aortic Bypass | <input type="checkbox"/> Coronary Bypass | <input type="checkbox"/> Liposuction |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Coronary Stent/Heart
Catheterization | <input type="checkbox"/> Lumpectomy |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> C-Section | <input type="checkbox"/> Lung Surgery |
| <input type="checkbox"/> AV Fistula | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Dialysis Catheter | <input type="checkbox"/> Neck Surgery |
| <input type="checkbox"/> Bowel Obstruction | <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Brain Surgery | <input type="checkbox"/> Exploratory
Laparotomy/Laparoscopy | <input type="checkbox"/> Peripheral Arterial Bypass |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Gall Bladder Removal | <input type="checkbox"/> Repair of Fracture |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Hernia Repair: _____ | <input type="checkbox"/> Shoulder Surgery |
| <input type="checkbox"/> Bronchoscopy | | |

- Spinal Fusion
- Stomach Surgery
- Thyroid Surgery
- Tonsils

Urologic Surgeries:

- Bladder Suspension
- Circumcision
- Cystectomy
- Incontinence Surgery
- Kidney Stone

- Nephrectomy
- Prostatectomy
- Scrotal
- Transurethral Prostatectomy
- Transurethral Resection of Bladder Tumor
- Tubal Ligation
- Vasectomy

NONE OF THE ABOVE APPLY

Other Surgeries Not Listed:

Family History (Please only if you have a family history of any of the following):

- | | | |
|---|--|---|
| <input type="checkbox"/> Unknown | <input type="checkbox"/> DVT/Blood Clot in Legs | <input type="checkbox"/> Bladder Cancer |
| <input type="checkbox"/> Unremarkable | <input type="checkbox"/> High Cholesterol/Lipids | <input type="checkbox"/> Kidney Cancer |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung Cancer | |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Melanoma | <input type="checkbox"/> NONE OF THE ABOVE APPLY |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Ovarian Cancer | Other Issues Not Listed: |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Pancreatic Cancer | _____ |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Pulmonary Embolus | _____ |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Renal Disease | _____ |
| <input type="checkbox"/> CVA or Stroke | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Skin Cancer | _____ |
| <input type="checkbox"/> Diabetes – Type 1 (juvenile) | <input type="checkbox"/> Sudden Death | _____ |
| <input type="checkbox"/> Diabetes – Type 2 (adult) | <input type="checkbox"/> Suicide | _____ |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Thyroid Disease | _____ |

Urologic Family History:

Social History (Please your answers to the following):

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Single | <input type="checkbox"/> Employed | <input type="checkbox"/> Children |
| <input type="checkbox"/> Married | <input type="checkbox"/> Unemployed | <input type="checkbox"/> Religious Preference affecting care |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Disabled | <input type="checkbox"/> Live at Home |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Retired | <input type="checkbox"/> Live in Care Facility |
| <input type="checkbox"/> Significant Other | <input type="checkbox"/> Occupation | |

Risk Factors (Please your answers to the following):

- Tobacco Use:** Cigarettes Yes No
 Amount Pk/Day: _____
 Current
 Year Started: _____

- Risk Factors Cont ~**
 Cigars Yes No
 Amount #/Wk: _____

Smokeless Yes No
Amount Per Day: _____
 Quit
Year Quit: _____
Pack/Years: _____
 Never
Passive Smoke Exposure:

Yes No
Illegal Drug Use:
 Yes No

HIV High Risk Behavior:
 Yes No

Caffeine Use (drinks/day):

Alcohol Use: Yes No
Type: _____
Amount/day: _____

Please complete back of form ~

Review of Systems (Please only if you are currently suffering from any of the following):

Allergy

- Allergic Rash
- Hay Fever
- Recurrent Infections
- Urticaria (hives)

Blood System

- Abnormal Bruising
- Bleeding
- Enlarged Lymph Nodes

Cardiovascular

- Chest Pains
- Fainting
- Heart Attack
- Palpitations
- Swelling of legs
- Shortness of Breath
- Shortness of Breath/Lying Down

Dermatologic (Skin)

- Dryness
- Itching
- Rash
- Suspicious Lesions

Ear/Nose/Throat

- Decreased Hearing
- Ear discharge
- Earache
- Hoarseness
- Nasal Congestion
- Nosebleeds
- Sore Throat
- Tinnitus

Endocrine

- Cold Intolerance
- Excessive Eating
- Excessive Thirst
- Heat Intolerance
- Increased Urine Output
- Unusual Weight Change

Eyes

- Blurring

- Discharge
- Double Vision
- Eye Pain
- Irritation
- Light Sensitivity
- Vision Loss

Gastrointestinal

- Abdominal Pain
- Bloody Stools
- Change in Bowel Habits
- Constipation
- Dark Stools
- Diarrhea
- Difficulty Swallowing
- Gas/Bloating
- Indigestion/Heartburn
- Jaundice
- Nausea
- Pain with Swallowing
- Vomiting

General

- Chills
- Fatigue/Weakness
- Fever
- Loss of Appetite
- Sleep Disorder
- Sweats
- Weight loss

Genitourinary

- Blood in Urine
- Burning with Urination
- Decreased sex drive
- Erectile Dysfunction
- Incontinence
- Urinary Frequency
- Urinary Hesitancy
- Abnormal Vaginal Bleeding
- Vaginal Discharge
- Pelvic Pain

Musculoskeletal

- Arthritis
- Back Pain
- Joint Pain
- Joint Swelling
- Muscle Cramps
- Muscle Weakness
- Restless Legs at Night
- Stiffness

Neurologic

- Abnormal Touch Sensation
- Difficulty Walking
- Dizziness
- Frequent Falls
- Frequent Headaches
- Seizures
- Temporary Blindness
- Tremors
- Paralysis

Psychiatric

- Anxiety
- Depression
- Hallucinations
- Memory Loss/Confusion
- Paranoia
- Phobia
- Suicidal Thoughts

Respiratory

- Asthma
- Blood in Sputum
- Chest Pain
- Cough
- Wheezing
- Sleep Apnea

NONE OF THE ABOVE APPLY

Other Issues Not Listed: