

OREGON UROLOGY INSTITUTE

Better Options. Better Care.

Patient Medical Information

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 \checkmark only if you have a history of any of the following):

- | | | |
|---|--|--|
| <input type="checkbox"/> Abnormal Heart Rhythm | <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Diabetes – Type 1 (juvenile) |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Diabetes – Type 2 (adult) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Diverticulitis/Diverticulosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> DVT/Blood Clots in Legs |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> COPD | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Crohns/Ulcerative Colitis | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Dementia | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Head/Neck Cancer |

Past Medical History Cont ~

- 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

- Kidney Failure
- Kidney Stone(s)
- Prostate Cancer
- Pyelonephritis
- Renal Failure
- Urinary Tract Infection

NONE OF THE ABOVE APPLY

Other Issues Not Listed:

Past Urologic History:

- Bladder Cancer
- Dialysis
- Incontinence
- Infertility
- Kidney Cancer

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

- Abdominoplasty/
Tummy Tuck
- Amputation
- Aneurysm Repair
- Angioplasty
- Antireflux Surgery
- Aortic Bypass
- Appendectomy
- Arthroscopy
- AV Fistula
- Back Surgery
- Bowel Obstruction
- Brain Surgery
- Breast Augmentation
- Breast Reduction
- Bronchoscopy
- Carotid Endarterectomy
- Carpal Tunnel
- Carotid Artery Surgery
- Cataract
- Colon Surgery
- Coronary Bypass
- Coronary Stent/Heart
Catheterization
- C-Section
- Defibrillator
- Dialysis Catheter
- Ear Tubes
- Exploratory
Laparotomy/Laparoscopy
- Gall Bladder Removal
- Hernia Repair: _____
- Hip Replacement
- Hysterectomy
- Hysterectomy with Removal
of Ovaries
- Knee Replacement
- Laminectomy
- Liposuction
- Lumpectomy
- Lung Surgery
- Mastectomy
- Neck Surgery
- Pacemaker
- Peripheral Arterial Bypass
- Repair of Fracture
- Shoulder Surgery
- 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 \checkmark only if you have a family history of any of the following):

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

Social History (Please \checkmark 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 |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Disabled | affecting care |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Retired | <input type="checkbox"/> Live at Home |
| <input type="checkbox"/> Significant Other | <input type="checkbox"/> Occupation | <input type="checkbox"/> Live in Care Facility |
-

Risk Factors (Please \checkmark your answers to the following):

Tobacco Use:

- | | |
|---|--|
| <input type="checkbox"/> Current | <input type="checkbox"/> Quit |
| Year Started: _____ | Year Quit: _____ |
| Cigarettes <input type="checkbox"/> Yes <input type="checkbox"/> No | Pack/Years: _____ |
| Amount Pk/Day: _____ | <input type="checkbox"/> Never |
| Cigars <input type="checkbox"/> Yes <input type="checkbox"/> No | Passive Smoke Exposure: |
| Amount #/Wk: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Smokeless <input type="checkbox"/> Yes <input type="checkbox"/> No | Illegal Drug Use: |
| Amount Per Day: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> 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

- 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:
