

Name \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

**Chief Complaint**

What is the main reason for your visit today (Please Describe in detail)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HPI: (omit if no symptoms)**

Locations: \_\_\_\_\_ abdomen \_\_\_\_\_ back \_\_\_\_\_ pelvis \_\_\_\_\_ genitals \_\_\_\_\_ other: \_\_\_\_\_

Duration: How long has this been present? \_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

Quality: \_\_\_\_\_ dull \_\_\_\_\_ sharp \_\_\_\_\_ ache \_\_\_\_\_ burning \_\_\_\_\_ gripping \_\_\_\_\_ pressure

Severity: (10 being most severe) 1 2 3 4 5 6 7 8 9 10

Context: Anything else happening at the same time? \_\_\_\_\_

How long does the problem last? \_\_\_\_\_ minutes \_\_\_\_\_ hours \_\_\_\_\_ other: \_\_\_\_\_

If not constant, how often does it recur? \_\_\_\_\_

Modifiers: Anything make the problem better? \_\_\_\_\_

Anything make the problem worse? \_\_\_\_\_

Any other symptoms associated? \_\_\_\_\_

Have you received any treatment for this ? Y N Please specify: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Urologic History:**

**ROS:**

Do you have any of the following symptoms?

Blood in urine Y N

Blood in ejaculate Y N

Urinary infections Y N

Burning Y N

Wetting with cough/sneeze Y N

Wetting when urge to void Y N

MEN ONLY-have you had a PSA?

Result \_\_\_\_\_ Date \_\_\_\_\_

Do you have trouble with:

erections? Y N Do you want help? Y N

sex drive? Y N Do you want help? Y N

**Past History:** In the past have you had or been told you had (if yes, please explain)

Blood in urine Y N \_\_\_\_\_

Blood in ejaculate Y N \_\_\_\_\_

Urinary infections Y N \_\_\_\_\_ bladder \_\_\_\_\_ kidney \_\_\_\_\_ other: \_\_\_\_\_

Surgery on urinary system Y N \_\_\_\_\_

Surgery on sex organs Y N \_\_\_\_\_

Urinary stones Y N \_\_\_\_\_

Urinary tumors(cancer) Y N \_\_\_\_\_

**Family History:** Anyone in your family with any of the above ? \_\_\_\_\_ Specify: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Any urologic cancers in your family? \_\_\_\_\_ Prostate \_\_\_\_\_ Bladder \_\_\_\_\_ Kidney \_\_\_\_\_ Other(please specify): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_