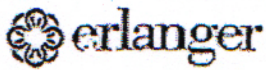

Academic Urologists at Erlanger
Patient Medical History Form

Name:		Referring Physician:		Date:
Birthday:	Age:	Level of Education:	Occupation:	Height:
Marital Status (circle): Married Single Divorced Separated Widowed			Number of Children:	Weight:

1 Reason for Visit:

2 History of Present Illness: (Please answer the following questions completely or write N/A)

Where is your problem located?
How severe is your problem?
When did you first notice the problem?
Is the problem constant or variable? (circle) : Dull then Sharp Very sharp then leaves Always there Other:
Is anything else occurring at the same time? (circle): Yes No (If Yes, please explain)
Does anything make the problem better?
Does anything make the problem worse?
Does the problem interfere with your normal functions? (circle): Yes No (If Yes, please explain)

3 Past Medical Problems

Past Medical Problems			List All Other Medical Problems
Heart Disease	Yes	No	
Pacemaker/Defibrillator	Yes	No	
Lung Disease	Yes	No	
Diabetes	Yes	No	
High Blood Pressure	Yes	No	
Bowel Problems	Yes	No	
Stroke/Seizures	Yes	No	
Kidney Problems	Yes	No	
Bleeding Problems	Yes	No	

4 Past Surgeries: or ☐ NONE

Please List All Surgeries:	Year

5 Current Medications: or ☐ No Medications

6 Allergies: or ☐ NONE

Are you allergic to:			List All Medication Allergies:
Latex	Yes	No	
Shellfish	Yes	No	
X-Ray Dye	Yes	No	
Iodine	Yes	No	

7 Family History

Prostate Cancer	Yes	No	Heart Disease	Yes	No
Diabetes	Yes	No	Kidney Stones	Yes	No
Mother's medical problems:					
Father's medical problems:					
Other family illnesses:					

8 Social History

Have you ever smoked?	Yes	No
If you smoke, how many packs per day?		
How long ago did you quit smoking?		
Do you drink alcohol?	Yes	No
If yes, how much? (circle): rare moderate heavy		
Have you ever used drugs?	Yes	No

MD Review:	Date:

Academic Urologists at Erlanger
Bladder Questionnaire

Patient Name ______________________ Date of Visit ________________

Please circle or indicate the appropriate response to each question.

1. Do you ever leak urine or lose control of urination? Yes No

2. If you lose control, do you know when it happens or do you just find yourself wet?
   _____ Know when it happens
   _____ Find myself wet

3. How often do you lose control and wet yourself or your pads:
   when you cough or sneeze? Never Monthly Weekly Daily
   when you engage in physical activity? Never Monthly Weekly Daily
   when you raise yourself from a sitting to standing position? Never Monthly Weekly Daily

4. How often do you wear pads or other forms of protection because of wetting? Never Monthly Weekly Daily

5. On average, how many pads do you use a day? _______

6. On average, how wet are you when change your pads? Dry Moist Damp Wet Soaked

7. How badly does loss of urinary control bother you?
   On a scale of 0 to 10 (0 is not at all, 10 is intolerable) _________

8. How often must you push or strain to start urination? Never Monthly Weekly Daily

9. How would you describe the usual force of the urinary stream? Strong Weak Interrupted Dribbling

10. How often do you lose control of urination and wet yourself or your pads because you feel a strong urge and cannot stop it? Never Monthly Weekly Daily

11. How many pregnancies have you had?
    Total pregnancies _________
    Vaginal deliveries _________
    C-section deliveries _________

MD Review: _________ Date: _________

ACADEMIC UROLOGISTS AT ERLANGER

Argil Wheelock, M.D.
Norman Galen, M.D.
Ryan Glass, M.D.

960 E. Third Street
Suite 208
Chattanooga, TN 37403

PATIENT REVIEW OF SYSTEMS FORM

Name: ______________________________ Date of Birth: ______________

Do you now or have you ever had any problems related to the following systems? Please check and explain all that apply.

Constitutional/General Symptoms

_____ Fever
_____ Chills
_____ Headaches
_____ Recent weight gain/loss
_____ Fatigue
_____ Recurrent infections
_____ Other

Eyes

_____ Blurred vision
_____ Double vision/blindness
_____ Glasses/Contact Lenses
_____ Glaucoma
_____ Eye pain
_____ Other

Ear, Nose, Throat, Mouth

_____ Deafness/hearing aids
_____ Ear infections
_____ Ear drainage/pain
_____ Sinus problems
_____ Nose bleeds
_____ Sore Throat
_____ Hoarseness
_____ Denture/oral appliances
_____ Other

Cardiovascular

_____ Chest pain/discomfort/tightness
_____ High/Low Blood pressure
_____ Varicose veins
_____ Swollen Ankles
_____ Heart murmur
_____ Other

Allergic/Immunologic

_____ Hay fever
_____ Drug Allergies
_____ Other

Musculoskeletal

_____ Joint pain
_____ Neck pain
_____ Back pain
_____ Other

Integumentary

_____ Skin rash
_____ Boils
_____ Persistent itch
_____ Other

Neurological

_____ Tremors
_____ Dizzy Spells
_____ Numbness/tingling
_____ Other

Psychologic

_____ Depression
_____ Alcohol/drug problems
_____ Nervousness/Anxiety attacks
_____ Other

Endocrine

_____ Excessive thirst
_____ Too hot/cold
_____ Numbness/tingling
_____ Sugar in urine
_____ Other

Hemotologic/Lymphatic

_____ Swollen glands
_____ Blood clotting problems
_____ Swollen lymph nodes
_____ Other

Respiratory

_____ Wheezing
_____ Shortness of Breath
_____ Productive bloody cough
_____ Bronchitis/asthma
_____ Emphysema/COPD
_____ Pneumonia
_____ Other

Gastrointestinal

_____ Abdominal pain
_____ Change in bowel habits
_____ Change in appetite
_____ Black stools/change in stools
_____ Yellow skin
_____ Nausea/vomiting
_____ Indigestion/heartburn
_____ Do you use antacids?
_____ Special diet
_____ Colitis
_____ Diverticulitis
_____ Hiatal Hernia/reflux
_____ Irritable bowl syndrome
_____ Ulcers
_____ Pancreatitis
_____ Rectal bleeding/pain
_____ Hemorrhoids
_____ Other

Genitourinay/Gyn.

_____ Urine retention
_____ Painful urination
_____ Frequency/urgency
_____ Incontinence
_____ Elevated PSA
_____ Prostate nodules
_____ Blood in urine
_____ Kidney stones
_____ Kidney failure
_____ Impotence
_____ Bladder problems
_____ Blood in urine
_____ Testicular/groin pain
_____ Problems starting/stopping urine
_____ Uterine problems
_____ Ovarian Problems
_____ Other

_____ **All other systems are negative**

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# Answers	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician Signature ____________________ Date Reviewed __________

ACADEMIC UROLOGY @ ERLANGER

Patient Name______________________ Address:____________________________

Social Security #_________________________ DOB_________________________

Home Phone Number_______________________ Cell Phone___________________

EMERGENCY CONTACT:

Name______________________________ Relation to Patient__________________

Contact Numbers:____

______ I authorize you to leave a voicemail message on my phone, answering machine, regarding medication, labs, appointments or any instructions.
Yes__________ No_________________

______ I authorize you to leave a message regarding medication, labs, appointments, or any instructions with anyone answering my phone except for the following persons:____

PHARMACY INFORMATION

PHARMACY NAME:____

PHARMACY PHONE:_________________________ FAX:____________________

MEDICATION/FOOD ALLERGIES:____

PHYSICIAN INFORMATION

Primary Care:________________________________ Phone:___________________

Referring Doctor:_____________________________ Phone:___________________

Cardiologist:_________________________________ Phone:___________________