ACADEMIC UROLOGISTS AT ERLANGER

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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 _____

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American Urological Association

Benign Prostatic Hypertrophy Symptom Score Index

Patient Name _____ Date of Visit _____

Please circle the number that best applies to you for each question.

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. How often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. How often have you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. How often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. How often have you had a weak urinary stream?	0	1	2	3	4	5
6. How often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 time	2 times	3 times	4 times	5 times
7. How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add the score for each question above, and write the total in the space to the right.

SYMPTOM SCORE = 1-7 Mild 8-19 Moderate 20-35 Severe **Total** _____

Quality of Life	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now for the rest of your life?	0	1	2	3	4	5	6

MD Review: _____ Date: _____

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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:_____

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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			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			List All Medication Allergies:
Are you allergic to:			
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: