

# 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

**Hematologic/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 bowel syndrome
- Ulcers
- Pancreatitis
- Rectal bleeding/pain
- Hemorrhoids
- Other

**Genitourinary/Gyn.**

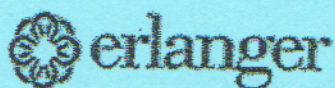
- Urine retention
- Painful urination
- Frequency/urgency
- Incontinence
- Elevated PSA
- Prostate nodules
- Blood in urine
- Kidney stones
- Kidney failure
- Impotence
- Bladder problems
- Blood in urine
- Testicular/groin pain
- Problems starting/stopping urine
- Uterine problems
- Ovarian Problems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

All other systems are negative

Office use only

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

Physician Signature \_\_\_\_\_ Date Reviewed \_\_\_\_\_



Academic Urologists at Erlanger  
 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: \_\_\_\_\_

# 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: \_\_\_\_\_

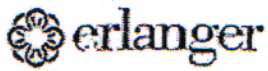
MEDICATION/FOOD ALLERGIES: \_\_\_\_\_

## PHYSICIAN INFORMATION

Primary Care: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Cardiologist: \_\_\_\_\_ Phone: \_\_\_\_\_



# 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			List All Other Medical Problems			4 Past Surgeries: or <input type="checkbox"/> NONE	
Heart Disease	Yes	No				Please List All Surgeries:	Year
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					

**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:
------------	-------