*Clarksville Urology Center**
New Patient Urologic History Form

Patient's Name: ____
(Last) (First) (MI) (Date)

Age: ____ **DOB:**________**Referring Dr:**________________**Primary Dr:**____________________

***Allergies*:** Are you allergic to:

Latex	Iodine / Betadine	Penicillin
Dye / IV Contrast	Tape / Adhesives	Sulfa
Shellfish / Shrimp	Anesthetics	Cipro / Levaquin

☐ I have no medication allergies

Medication allergies: (**List all**)

____

Medications

Do you take any medications? ☐ Yes ☐ No

Are you currently taking the following blood thinners?: ☐ Aspirin ☐81 mg or ☐325 mg
☐ Motrin ☐ Aleve ☐ Ibuprofen ☐ Celebrex ☐ Mobic ☐Other: ______________________
☐ Coumadin ☐ Warfarin ☐ Plavix ☐ Pradaxa ☐ Xarelto ☐ Eliquis ☐ Heparin ☐ Lovenox

Please list all the medications you take with the dosage and frequency

Medication:	Dose:	How Often:

Please list all **Vitamins & Supplements such as Vitamin E, Fish oil, Herbal preparation, Garlic, etc**

Past & Present Medical Problems

Irregular heartbeat
Carotid artery disease
Congestive heart failure
High blood pressure
High cholesterol
Heart attack
Peripheral vascular disease
Heart valvular disease
Renal artery stenosis
Heart disease
Asthma
Bronchitis
COPD
Cystic fibrosis
Pneumonia
Pulmonary embolism
Sarcoidosis
Sleep apnea
Tuberculosis
Cirrhosis
Crohn's disease
Heartburn/GERD
Hepatitis B
Hepatitis C
Irritable bowel syndrome
Peptic ulcer disease
Ulcerative colitis

Diverticulosis
Kidney failure
Endometriosis
Polycystic kidney disease
Kidney stones
Vesicoureteral reflux
Kidney infections/UTI
Kidney obstruction
Enlarged prostate/BPH
Prostate infection
STD's
Fibromyalgia
Gout
Osteoporosis
Rheumatoid arthritis
Polio
Artificial joints
Lupus
Addison's Disease
Cushing's disease
Diabetes
Hyperthyroidism
Hypothyroidism
Alzheimer's
Bipolar
Stroke
Dementia

Multiple sclerosis
Myasthenia gravis
Parkinson disease
Seizures
TIA
Anemia
Sickle cell anemia
Blood clots
HIV/AIDS
Glaucoma
Drug dependency
Depression
Bladder cancer
Breast cancer
Cervical cancer
Colon cancer
Kidney cancer
Lung cancer
Penile cancer
Prostate cancer
Skin cancer
Testicular cancer
Uterine cancer
Cancer, Other:
____
Other:_________________
____

Female history

Number of pregnancies: _______ Number of Deliveries: ________ ☐ Vaginal ☐ C-Section
Have you had a hysterectomy? ☐ Yes ☐ No When? __________Why? ______________________________
Have you had any prior bladder surgeries/when? ____
Have you had a bladder tack/when? ____
Have you had a sling/when? ____

Surgical History

Date:	Surgery:	Date:	Surgery:

Family History **(please indicate which family member)**

Urinary infections	Kidney stones	Prostate cancer
Bleeding disorders	Diabetes	Kidney cancer
Heart disease	Bladder cancer	Other:_____________

Tobacco/ Alcohol History

Do you currently smoke? ☐ Yes ☐ No How much? ___________________________
Did you smoke in the past? ☐ Yes ☐ No How long? ____________ When did you quit? _________________
Do you drink alcohol? ☐ Yes ☐ No How many drinks per day? __________________________________
Do you use recreational drugs? ☐ Yes ☐ No Substances: ____

What is the ***main reason*** for your visit today? Write in your own words on the lines provided:

____

____

When did you first notice the problem? ____

Location of the problem? (You may choose more than one location)

Abdomen	Pelvis	Flank
Back	Penis	Bladder
Groin	Rectum	Genitalia

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem.

1 2 3 4 5 6 7 8 9 10

How long does the problem last? ____

Is the problem: ☐ Constant ☐ Variable ☐ Seldom

Does anything make the problem worse?

Moving around	Standing up
Lying on side	Other:________________________

Does anything make the problem better? ____

Does the problem interfere with your normal activities? ☐ Yes ☐ No

What testing have you had to evaluate your urological problem?

I have had no tests to evaluate this problem

X-ray	Ultrasound	Urodynamic Testing
CT scan	Nuclear bone scan	Other: ___________
MRI	Nuclear renal scan	Unsure
IVP	Urine specimen	
Blood tests	Cystoscopy	

Where was the test performed? ____

Do you have blood in the urine? ☐Yes ☐ No If no, have you ever had blood in the urine? ☐Yes ☐ No

If yes:

Every time I urinate
Intermittently
Painful
Painless

It occurs at the beginning of urination
It occurs at the end of urination

It occurs the entire urine stream
Blood clots are passed in the urine

Do you experience any of the following?

Urinary urgency
Urinary frequency
Burning with urination

Weak stream
Straining to urinate
Trouble starting stream

Dribbling

How many times do you wake up to urinate at night? 0 1 2 3 4 5 6 7 8 9 10

Do you feel like your emptying your bladder completely? ☐Yes ☐ No

Do you leak urine? ☐Yes ☐ No

Is your leakage associated with the urge to urinate? ☐Yes ☐ No

Is your leakage associated with coughing, laughing, jumping, sneezing, or exercising? ☐Yes ☐ No

Do you wear protective pads? ☐Yes ☐ No

How many Pads/day? _____ Liners/day? ______ Diapers/day? _____ Other: ______________________

Are they usually: ☐ Dry ☐Moist ☐Wet ☐Soaked

Men only:

Do you have a problem with libido/desire? ☐ Yes ☐ No

Do you have a problem achieving or maintaining an erection? ☐ Yes ☐ No

Have you tried any medications for erectile dysfunction? ☐ Yes ☐ No Please indicate which medication(s) below:

☐Viagra ☐Cialis ☐Levitra ☐Staxyn ☐MUSE ☐BiMix ☐TriMix ☐ VED ☐Other:_________________

Men & Women:

Are there any other urologic issues you would like to discuss with Dr. DeLaurentis today? ☐ Yes ☐ No

(Please explain:) ____

Thank you for taking the time to complete your urological health questionnaire. Welcome to our practice!
Dr. Dino DeLaurentis, DO, FACOS, PLC *CLARKSVILLE UROLOGY CENTER IS NOT A PARTNERSHIP

REVIEW OF SYSTEMS

Name:______________________________________ Date:______________________

Please ✔ check only the problems that ***currently*** apply to you

CONSTITUTIONAL

- Fever
- Chills
- Weight gain
- Weight loss

EYES

- Blurred vision
- Vision loss

EARS/ NOSE/ THROAT

- Hearing loss
- Sinus problems
- Difficulty swallowing
- Sore throat
- Dental problems
- Nose bleeds

CARDIOVASCULAR

- Chest pain
- Palpitations
- Irregular heartbeat
- Swelling of feet/ extremities

RESPIRATORY

- Shortness of breath
- Chronic cough
- Coughing up blood

GASTROINTESTINAL

- Poor appetite
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Abdominal pain
- Blood in stool
- Heartburn

GENITOURINARY

- Blood in urine
- Leakage of urine
- Weak stream
- Frequency urination
- Urge to void suddenly
- Getting up at night to urinate
- Problems with erections
- Pain with intercourse
- Bladder pain
- Pelvic pain
- Burning with urination
- Frequent urine infections

MUSCULOSKELETAL

- Back pain
- Joint pain
- Muscle aches

INTEGUMENTARY/SKIN

- Rash
- Atypical moles
- Itchy skin

NEUROLOGIC

- Numbness
- Weakness
- Dizziness

HEMATOLOGIC/ LYMPHATIC

- Easy bruising
- Bleeding tendency
- Swollen lymph glands

ENDOCRINE

- Excessive thirst
- Hot/cold Intolerance
- Hormone problems
- Fatigue

ALLERGY

- Medication allergy
- Latex allergy
- Seasonal allergies

PSYCHIATRIC

- Depression
- Anxiety

*****Healthcare provider only:*** The above systems have been reviewed by: ________________
Physician's initials