Clarksville Urology
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 you're 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:_____

Do you have a lump, bump or curvature of the penis? ☐ Yes ☐ No

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

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