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Urology New Patient (Male)

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

Reason for your visit today? Please be precise.

Physician that referred you for care at John Muir Urology: _____

PAST MEDICAL HISTORY

Do you have or have you had any of the following conditions?	YES	NO	Type / Year Diagnosed
Cancer (kidney, bladder, prostate, testicle, penis)	<input type="checkbox"/>	<input type="checkbox"/>	
Heart (chest pain, heart attack, murmur)	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had an EKG?	<input type="checkbox"/>	<input type="checkbox"/>	When/Where?
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	
Blood or clotting problems	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach/Liver (reflux, bleeding, hepatitis, etc)	<input type="checkbox"/>	<input type="checkbox"/>	
Bowels (change in bowel habits, constipation, diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	
Glands (Diabetes, thyroid, gout)	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal (arthritis, disc disease)	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes/Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs (Asthma, Emphysema, Pneumonia, shortness of breath, TB)	<input type="checkbox"/>	<input type="checkbox"/>	
Prostate Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Brain/Nervous System (seizure, "blackout spells")	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Illness (Nervous condition/Depression)	<input type="checkbox"/>	<input type="checkbox"/>	
Skin (rash, psoriasis, hives)	<input type="checkbox"/>	<input type="checkbox"/>	
Constitutional (unexplained weight loss, fevers, chills, night sweats)	<input type="checkbox"/>	<input type="checkbox"/>	
Any other illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any accidents/injuries within the last 24 months?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever received the Shingles Vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	

PAST SURGICAL HISTORY

Type of Operation	Surgeon	Date(s)

Do you have any artificial joints and/or heart valves? Yes No If yes, give which & date:
 Have you ever had a blood transfusion? Yes No If yes, when?

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Names of <i>ALL</i> Physicians			
Name	Phone	City	Specialty

FAMILY HISTORY			
RELATION	AGE(S)	STATE OF HEALTH	IF DECEASED, CAUSE/AGE OF DEATH
Mother			
Father			
Siblings			
Spouse			
Children			
Are you of Ashkenazi Jewish descent?		YES <input type="checkbox"/>	NO <input type="checkbox"/>

Please list any diseases that run in your family, such as cancer, kidney stones, diabetes, etc.	
Disease	Family member

REVIEW OF SYSTEMS					
Have you experienced any of these problems during the past month?					
	YES	NO		YES	NO
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Mood changes or Depression	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Skin rash or itching	<input type="checkbox"/>	<input type="checkbox"/>	Frequent indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Loss of balance or coordination	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea or constipation	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Vision trouble	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contacts or glasses?	<input type="checkbox"/>	<input type="checkbox"/>	Foul-smelling urine	<input type="checkbox"/>	<input type="checkbox"/>
Arm or leg weakness	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Sinus drainage	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>			
Hoarseness or change in voice	<input type="checkbox"/>	<input type="checkbox"/>			
Sores in mouth or lip	<input type="checkbox"/>	<input type="checkbox"/>			
Cough	<input type="checkbox"/>	<input type="checkbox"/>			
Coughed up or spit up blood	<input type="checkbox"/>	<input type="checkbox"/>			

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URINARY SYMPTOMS

Check appropriate box:		YES	NO
When you urinate, does the stream start immediately?		<input type="checkbox"/>	<input type="checkbox"/>
When the stream starts to flow does it come out:	<input type="checkbox"/> FAST <input type="checkbox"/> MEDIUM <input type="checkbox"/> SLOW		
Once the stream is flowing, does it flow continuously?		<input type="checkbox"/>	<input type="checkbox"/>
Do you push or strain to urinate?		<input type="checkbox"/>	<input type="checkbox"/>
When you are finished, do you feel empty?		<input type="checkbox"/>	<input type="checkbox"/>
Do you awaken at night to urinate?		<input type="checkbox"/>	<input type="checkbox"/>
If YES, how many times? _____			
Do you leak urine?		<input type="checkbox"/>	<input type="checkbox"/>
If YES, how many pads do you use per day? _____			
Does it burn or sting when you urinate?		<input type="checkbox"/>	<input type="checkbox"/>
How often do you urinate during the day? <i>Ex: Every 30 min? Every 2 hrs?</i> _____			
Do you get the urge to urinate so bad that you do not think you will get to the bathroom in time?		<input type="checkbox"/>	<input type="checkbox"/>
Have you had a sexually transmitted disease?		<input type="checkbox"/>	<input type="checkbox"/>
<i>check one:</i> <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes <input type="checkbox"/> Genital Warts <input type="checkbox"/> Other: _____			
Have you ever had an infection in your urinary tract? (Kidneys, bladder, prostate)		<input type="checkbox"/>	<input type="checkbox"/>
Is there pain in your: (<i>check all that apply</i>)			
<input type="checkbox"/> Lower abdomen?			
<input type="checkbox"/> Groin?			
<input type="checkbox"/> Testicles?			
<input type="checkbox"/> Behind the scrotum or testicles?			

KIDNEY STONES

	YES	NO
1. Do you have pain in the flank or kidney area?	<input type="checkbox"/>	<input type="checkbox"/>
If YES: <input type="checkbox"/> Left <input type="checkbox"/> Right		
2. Have you ever had a kidney stone?	<input type="checkbox"/>	<input type="checkbox"/>
3. If NO, skip to next section		
If YES,		
a) Date(s)? _____		
b) How many? _____		
c) Passed spontaneously?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
d) How was the stone removed?	<input type="checkbox"/> Surgically <input type="checkbox"/> Basket	
e) Lithotripsy (shock therapy)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
4. What was the stone made of?	<input type="checkbox"/> Calcium <input type="checkbox"/> Uric Acid <input type="checkbox"/> Other: _____	
5. Were you placed on stone prevention therapy?	<input type="checkbox"/>	<input type="checkbox"/>
6. What type? _____		

HEMATURIA

	YES	NO
1. Have you seen blood in your urine?	<input type="checkbox"/>	<input type="checkbox"/>
2. If NO, skip to question 5		
If YES,		
a) Was the blood only at the beginning of the stream?	<input type="checkbox"/>	<input type="checkbox"/>
b) Throughout the stream?	<input type="checkbox"/>	<input type="checkbox"/>
c) At the end of the stream?	<input type="checkbox"/>	<input type="checkbox"/>
3. Was the bloody urine (<i>check all that apply</i>)		
<input type="checkbox"/> Tea colored		
<input type="checkbox"/> Rose wine/ cranberry colored		
<input type="checkbox"/> Burgundy wine colored		
<input type="checkbox"/> Clots		
4. Was there any pain or burning with the bloody urine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has a doctor found blood in your urine under a microscope?	<input type="checkbox"/>	<input type="checkbox"/>

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ERECTILE DYSFUNCTION		YES	NO
1. Do you have problems with erections?		<input type="checkbox"/>	<input type="checkbox"/>
2. If YES,			
a)	Do you awaken in the morning or night with a good erection?	<input type="checkbox"/>	<input type="checkbox"/>
b)	Does your sexual partner give you plenty of stimulation (oral/manual) to help you achieve or maintain an erection?	<input type="checkbox"/>	<input type="checkbox"/>
c)	Do you have trouble obtaining an erection?	<input type="checkbox"/>	<input type="checkbox"/>
d)	Do you have trouble maintaining an erection?	<input type="checkbox"/>	<input type="checkbox"/>
e)	Do you have curvature with erections?	<input type="checkbox"/>	<input type="checkbox"/>
f)	Do you have painful erections?	<input type="checkbox"/>	<input type="checkbox"/>
g)	Is sex an important part of your life?	<input type="checkbox"/>	<input type="checkbox"/>
3. On a scale of 1 to 10, rate the quality of your erections now (10 being when you were 18 years old) _____			
4. When attempting intercourse, how many times out of every 10 tries will you successfully penetrate and achieve orgasm? _____			

SOCIAL HISTORY		
(✓)	SUBSTANCE:	APPROXIMATE YEAR STARTED / FREQUENCY:
<input type="checkbox"/>	ALCOHOL	Year: <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Occasional/Social <input type="checkbox"/> Drinks/Day: _____
<input type="checkbox"/>	SMOKING STATUS	<input type="checkbox"/> Current/Every Day <input type="checkbox"/> Current/Some Days <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoker <input type="checkbox"/> Unknown
<input type="checkbox"/>	TOBACCO	Year: _____ Pack(s) A Day: _____ Quit: <input type="checkbox"/> NO <input type="checkbox"/> YES <i>If YES, Date Quit:</i> _____
<input type="checkbox"/>	STREET DRUGS/OTHER	Year: _____ Type: _____ Do you use needles? <input type="checkbox"/> NO <input type="checkbox"/> YES
<input type="checkbox"/>	HIV positive or AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO

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Prostate Health for Men Over 40

Are you bothered by urinary symptoms? Take this test- you may have BPH. BPH (benign prostatic hyperplasia is a non-cancerous enlargement of the prostate that occurs in many men over the age of 40.

Use this form to assess your symptoms, and share your results with your doctor.

To use this symptom scorecard: *Check one number in each line then add all checked numbers to get the total score. The total runs from 0 to 35 points with higher scores indicating more severe symptoms. Scores less than 7 are considered mild and generally do not warrant treatment.*

AUA and BPH SYMPTOM SCORE						
	Not at all	Less than 1 in 5 time(s)	Less than half the time	About half the time	More than half the time	Almost always
INCOMPLETE EMPTYING Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
FREQUENCY Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
INTERMITTENCY Over the past month, how often have you found you stopped and started again several times when you urinated?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
URGE TO URINATE Over the past month, how often have you found it difficult to postpone urination?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
WEAK STREAM Over the past month, how often have you had a weak urinary stream?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
STRAINING Over the past month, how often have you had to push or strain to begin urination?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
URINATING AT NIGHT Over the past month, 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?	NONE <input type="checkbox"/> 0	1 TIME <input type="checkbox"/> 1	2 TIMES <input type="checkbox"/> 2	3 TIMES <input type="checkbox"/> 3	4 TIMES <input type="checkbox"/> 4	5 TIMES <input type="checkbox"/> 5
SYMPTOM SCORE: 1-7 Mild, 8-19 Moderate, 20-35 Severe				Total: _____		

BOTHER SCORE DUE TO URINARY SYMPTOMS Rate the bothersomeness of your symptoms by checking the number below that best describes your feelings							
	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
BOTHERSOME OR URINARY SYMPTOMS How would you feel if you had to live with your urinary condition the way it was now, no better, no worse, for the rest of your life?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

