OREGON UROLOGY INSTITUTE

Better Options. Better Care.

Patient Medical Info

Full Name: ______________________ Date of Birth: ______________

Reason for today's visit: ______________________________________

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Height ____________ Weight ____________

Current Medications

Medication	Dose	How Often	Medication	Dose	How Often
Example: Atrovan	10 mg	1 a day			

Allergies to Medications (please circle) YES / NO If so, to what drug(s) and with what reaction(s):

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Past Medical History (Please mark the □ only if you have a history of any of the following):

□ Abnormal Heart Rhythm
□ Alzheimer's
□ Anemia
□ Asthma
□ Atrial Fibrillation
□ Autoimmune Disorder
□ Bleeding Disorder
□ Brain Tumor
□ Breast Cancer
□ Cervical Cancer
□ Cirrhosis
□ Clotting Disorder
□ Colon Cancer
□ Congestive Heart Failure
□ COPD
□ Coronary Artery Disease
□ Crohns/Ulcertive Colitis
□ Dementia
□ Depression
□ Diabetes – Type 1 (juvenile)
□ Diabetes – Type 2 (adult)
□ Diverticulitis/Diverticulosis
□ DVT/Blood Clots in Legs
□ Endometriosis
□ Fibromyalgia
□ GERD
□ Glaucoma

Past Medical History Cont.~

- ☐ Head/Neck Cancer
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol/Lipids
- ☐ Hypothyrodism
- ☐ Irritable Bowel Syndrome
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Lupus
- ☐ Lymphoma
- ☐ Multiple Sclerosis
- ☐ Myeloma
- ☐ Neurologic Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Pancreatitis
- ☐ Parkinsons Disease
- ☐ Peripheral Vascular Disease
- ☐ Pneumonia
- ☐ Pulmonary Emboli
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Spinal Cord Injury
- ☐ Stroke
- ☐ Thyroid Cancer
- ☐ Ulcer Disease/GI Bleed
- ☐ Uterine Cancer
- ☐ Valvular Heart Disease

Past Urologic History:

- ☐ Bladder Cancer
- ☐ Dialysis
- ☐ Incontinence
- ☐ Infertility
- ☐ Kidney Cancer
- ☐ Kidney Failure
- ☐ Kidney Stone(s)
- ☐ Prostate Cancer
- ☐ Pyelonephritis
- ☐ Renal Failure
- ☐ Urinary Tract Infection

Other Issues Not Listed:

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Past Surgical History (Please mark the ☐ only if you have had of any of the following):

- ☐ Abdominoplasty/ Tummy Tuck
- ☐ Amputation
- ☐ Aneurysm Repair
- ☐ Angioplasty
- ☐ Antireflux Surgery
- ☐ Aortic Bypass
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ AV Fistula
- ☐ Back Surgery
- ☐ Bowel Obstruction
- ☐ Brain Surgery
- ☐ Breast Augmentation
- ☐ Breast Reduction
- ☐ Bronchoscopy
- ☐ Carotid Endarterectomy
- ☐ Carpal Tunnel
- ☐ Cartotid Artery Surgery
- ☐ Cataract
- ☐ Colon Surgery
- ☐ Coronary Bypass
- ☐ Coronary Stent/Heart Catherization
- ☐ C-Section
- ☐ Defibrillator
- ☐ Dialysis Catheter
- ☐ Ear Tubes
- ☐ Exploratory Laparotomy/Laparoscopy
- ☐ Gall Bladder Removal
- ☐ Hernia Repair: __________
- ☐ Hip Replacement
- ☐ Hysterectomy
- ☐ Hysterectomy with Removal of Ovaries
- ☐ Knee Replacement
- ☐ Laminectomy
- ☐ Liposuction
- ☐ Lumpectomy
- ☐ Lung Surgery
- ☐ Mastectomy
- ☐ Neck Surgery
- ☐ Pacemaker
- ☐ Peripheral Arterial Bypass
- ☐ Repair of Fracture
- ☐ Spinal Fusion
- ☐ Stomach Surgery
- ☐ Thyroid Surgery
- ☐ Tonsils

Urologic Surgeries:

- ☐ Bladder Suspension
- ☐ Prostatectomy
- ☐ Scrotal
- ☐ Transurethral Prostatectomy
- ☐ Vasectomy
- ☐ Tubal Ligation
- ☐ Transurethral Resection of Bladder Tumor
- ☐ Cystectomy
- ☐ Incontinence Surgery
- ☐ Kidney Stone
- ☐ Circumcision
- ☐ Nephrectomy

Other Surgeries Not Listed:

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Family History (Please mark the □ only if you have a family history of any of the following):

□ Unknown
□ Unremarkable
□ Alcoholism
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Breast Cancer
□ Cervical Cancer
□ Coronary Heart Disease
□ Chronic Kidney Disease
□ Colon Cancer
□ CVA or Stroke
□ Depression
□ Diabetes – Type 1 (juvenile)
□ Diabetes – Type 2 (adult)
□ Dialysis

□ DVT/Blood Clot in Legs
□ High Cholesterol/Lipids
□ Hypertension
□ Kidney Transplant
□ Lung Cancer
□ Melanoma
□ Osteoporosis
□ Ovarian Cancer
□ Pancreatic Cancer
□ Pulmonary Embolus
□ Renal Disease
□ Seizures
□ Skin Cancer
□ Sudden Death
□ Suicide
□ Thyroid Disease

Urologic Family History:
□ Bladder Cancer
□ Kidney Cancer
□ Kidney Stones
□ Prostate Cancer

Other Issues Not Listed:

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Social History (Please mark the □ your answers to the following):

□ Single
□ Married
□ Divorced
□ Widowed
□ Significant Other

□ Employed
□ Unemployed
□ Disabled
□ Retired
□ Occupation

□ Children
□ Religious Conviction Declining Blood Products
□ Live at Home
□ Live in Care Facility

Risk Factors (Please mark the □ for your answers to the following):

Tobacco Use:

□ Current
Year Started: __________
Cigarettes □ Yes □ No
Amount Pk/Day: ______
Cigars □ Yes □ No
Amount #/Wk: _______
Smokeless □ Yes □ No
Amount Per Day: ______

□ Quit
Year Quit: ___________
Pack/Years: ___________
□ Never

Passive Smoke Exposure:
□ Yes □ No

Illegal Drug Use:
□ Yes □ No

HIV High Risk Behavior:
□ Yes □ No

Caffeine Use (drinks/day):
____

Alcohol Use: □ Yes □ No

Type: ___________________

Amount/day: ____________

Review of Systems (Please mark the □ only if you are currently suffering from any of the following):

Allergy
□ Allergic Rash
□ Hay Fever
□ Recurrent Infections
□ Urticaria

Blood System
□ Abnormal Bruising
□ Bleeding
□ Enlarged Lymph Nodes

Cardiovascular
□ Chest Pains
□ Fainting
□ Palpitations
□ Peripheral Edema
□ Shortness of Breath/Lying Down
□ Shortness of Breath

Dermatologic
□ Dryness
□ Itching
□ Rash
□ Suspicious Lesions

Ear/Nose/Throat
□ Decreased Hearing
□ Ear discharge
□ Earache
□ Hoarseness
□ Nasal Congestion
□ Nosebleeds
□ Sore Throat
□ Tinnitus

Endocrine
□ Cold Intolerance
□ Excessive Eating
□ Excessive Thirst
□ Heat Intolerance
□ Increase Urine Output
□ Unusual Weight Change

Eyes
□ Blurring
□ Discharge
□ Double Vision
□ Eye Pain
□ Irritation
□ Light Sensitivity
□ Vision Loss

Gastrointestinal
□ Abdominal Pain
□ Bloody Stools
□ Change in Bowel Habits
□ Constipation
□ Dark Stools
□ Diarrhea
□ Difficulty Swallowing
□ Gas/Bloating
□ Indigestion/Heartburn
□ Jaundice
□ Nausea
□ Pain with Swallowing
□ Vomiting

General
□ Chills
□ Fatigue/Weakness
□ Fever
□ Loss of Appetite
□ Melancholy
□ Sleep Disorder
□ Sweats
□ Weight loss

Genitourinary
□ Abnormal Uterine Bleeding
□ Abnormal Vaginal Bleeding
□ Absence of Menses
□ Bed Wetting
□ Blood in Urine
□ Burning with Urination
□ Decreased sex drive
□ Erectile Dysfunction
□ Genital Sores
□ Incontinence
□ Pelvic Pain
□ Urinary Frequency
□ Urinary Hesitancy
□ Vaginal Discharge

Musculoskeletal
□ Arthritis
□ Back Pain
□ Joint Pain
□ Joint Swelling
□ Leg Pain at Night
□ Leg Pain with Activity
□ Lower Back Pain
□ Muscle Cramps
□ Muscle Weakness
□ Restless Legs at Night
□ Stiffness

Neurologic
□ Abnormal Touch Sensation
□ Difficulty Walking
□ Dizziness
□ Frequent Falls
□ Frequent Headaches
□ Seizures
□ Temporary Blindness
□ Tremors
□Paralysis

Psychiatric
□ Anxiety
□ Depression
□ Hallucinations
□ Memory Loss/Confusion
□ Paranoia
□ Phobia
□ Suicidal Thoughts

Respiratory
□ Blood in Sputum
□ Chest Pain
□ Cough
□ Wheezing

Other Issues Not Listed:

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