Urology Associates of Lebanon, PA, P.C.

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Please note…the following information is very important to your health and treatment. Please take the time to fully complete this important information. Thank you in advance for your assistance!

Emergency Contact (Name & Phone #) _____

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Date _____

Name (First/M.I./Last) _____

Date of Birth (Month/day/year) _____Age_____

Address_____

City/State/Zip Code _____

Home Phone #_____ Cell Phone # _____ Work Phone # _____

Gender (Please Circle): Male Female

Race (Please Circle): White Black/African American Asian

American Indian/Alaska Native Native Hawaiian/Other Pacific Islander Other

Ethnicity (Please Circle): Spanish/Hispanic Origin Not of Spanish/Hispanic Origin

Decline this information

What is your primary language? _____

Social Security Number _____

Marital Status (please circle) Single Married Separated Divorced Widowed

Spouse's Name _____

Family Physician _____ Referring Physician _____

Employer _____

Reason for Visit _____

May we request information from your pharmacy(s) regarding your medications (current and history)? YES NO

What pharmacy do you use? _____

Patient Initials _____

Urologic History:

Do you have any of the following:	Please	Circle	Comments/Dates
1. Delay to start urinary flow	YES	NO	
2. Weak urinary flow	YES	NO	
3. Straining to urinate	YES	NO	
4. Interruption of urinary flow (stop/start)	YES	NO	
5. Frequent daytime urination, if yes, how often	YES	NO	
6. Get up at night to urinate, if yes, how often	YES	NO	
7. Poor urinary control/Leakage	YES	NO	
8. Retention/Unable to urinate	YES	NO	
9. Burning on urination	YES	NO	
10. Blood in the urine	YES	NO	
11. Passing of stones/gravel	YES	NO	
12. Urinary tract infections	YES	NO	
13. Kidney disease	YES	NO	
14. Cysts of the kidney	YES	NO	
15. Previous kidney/bladder x-rays, if yes, where did you Have them performed?	YES	NO	

16. How long have you had your urologic problem(s)? _____
17. Are your symptoms worsening? _____
18. What treatments/medications have you tried for these problems? _____

Past Medical History

	Please	Circle	Comments/Dates
High Blood Pressure	YES	NO	
High Cholesterol	YES	NO	
Diabetes Mellitus	YES	NO	
Heart Disease	YES	NO	
Do you have a pacemaker/defibrillator? If yes, specify	YES	NO	
Mitral Valve Prolapse	YES	NO	
Rheumatic Fever	YES	NO	
Cancer, if yes, specify location/type	YES	NO	
Stroke/Mini Stroke	YES	NO	
Arthritis	YES	NO	
Gout	YES	NO	
Bleeding Tendency	YES	NO	
Underactive Thyroid	YES	NO	
Overactive Thyroid	YES	NO	
Gastroesophageal reflux disease (GERD)	YES	NO	
Asthma	YES	NO	
Sleep Apnea....if yes do you use a CPAP?	YES	NO	
Glaucoma	YES	NO	
HIV/AIDS	YES	NO	
Hepatitis, if yes, specify type	YES	NO	
Parkinson's disease	YES	NO	
Have you ever had clostridium difficile (c-diff), Methicillin Resistant Staphylococcus Aureus (MRSA) or any other infectious disease?	YES	NO	
Do you premedicate with antibiotics prior to dental visits Or medical procedures? If yes, what antibiotic/dosage?	YES	NO	

Please list any medical conditions you have that are not noted above _____

List all previous surgeries & approximate dates _____

_____

_____

_____

_____

Have you ever had any problems with anesthesia? YES NO If yes, please specify. _____

_____

Current Medications & Dosages (Include over the counter products) _____

_____

_____

_____

_____

_____

Allergy Information:

Are you allergic to IV Contrast Dye/ Iodine / Shellfish?	YES	NO
Do you have any Latex allergies or sensitivities?	YES	NO
Do you have any drug allergies?	YES	NO

Please list any allergies: _____

_____

Family History:

Do you have any family history of bladder, kidney, or prostate cancer?	YES	NO
If yes, please specify _____		
Do you have any family history of kidney stones?	YES	NO
If yes, please specify _____		
Do you have any family history of kidney failure?	YES	NO
If yes, please specify _____		
Do you have any family history of any other urinary disorders?	YES	NO
If yes, please specify _____		

Social History:

Use of tobacco: Never Previously, Quit _____ currently, _____pk(s) /day

Use of alcohol: Never Rarely Moderate Daily

Use of drugs: Never Previously, Quit _____ Currently, Type _____

Occupation/Work History: _____

Review of Systems: Indicate if you have or have had any of the following

Hemostasis History:	Please	Circle	Comments/Dates
Bleeding tendencies	YES	NO	_____
Use of blood thinners	YES	NO	_____
Use of aspirin	YES	NO	_____
Have you ever had a blood transfusion?	YES	NO	_____
Neurological:			
Headaches	YES	NO	_____
Epilepsy/seizures/convulsions	YES	NO	_____
Dizzy/fainting spells	YES	NO	_____
Numbness/tingling	YES	NO	_____
Tremors	YES	NO	_____
Eyes:			
Blurred vision	YES	NO	_____
Double vision	YES	NO	_____
Do you wear glasses/corrective lens?	YES	NO	_____
Ears:			
Difficulty hearing	YES	NO	_____
Ringing in your ears	YES	NO	_____
Hearing aid(s)	YES	NO	_____
Ear infection	YES	NO	_____
Nose:			
Nosebleeds	YES	NO	_____
Sinus problems	YES	NO	_____
Throat/Mouth:			
Sore throat	YES	NO	_____
Difficulty swallowing	YES	NO	_____
Chipped or loose teeth	YES	NO	_____
Caps/Braces	YES	NO	_____
Bridgework/ Dentures…if yes, specify (full/partial/upper)	YES	NO	_____
Neck:			
Masses	YES	NO	_____
Thyroid disorders	YES	NO	_____
Parathyroid disorders	YES	NO	_____
Respiratory:			
Shortness of breath	YES	NO	_____
Asthma/wheezing	YES	NO	_____
Pneumonia	YES	NO	_____
Tuberculosis	YES	NO	_____
Frequent cough	YES	NO	_____
Coughing up blood	YES	NO	_____
Abnormal chest x-ray/ Lung Nodules	YES	NO	_____

	Please	Circle	Comments/Dates
Cardiovascular:			
Chest pain	YES	NO	
Palpitations/ Racing heart	YES	NO	
Leg cramps with walking	YES	NO	
Swelling of ankles	YES	NO	
Discolored/cold legs	YES	NO	
Varicose veins	YES	NO	
Gastrointestinal:			
Abdominal pain/cramping	YES	NO	
Nausea/vomiting	YES	NO	
Heartburn/indigestion	YES	NO	
Regular Bowel Movements	YES	NO	
Constipation/diarrhea	YES	NO	
Regular use of laxatives, if yes, specify	YES	NO	
Changes in bowel habits	YES	NO	
Dark stools	YES	NO	
Yellow/jaundice	YES	NO	
Musculoskeletal:			
Joint pain	YES	NO	
Arthritis	YES	NO	
Broken bones	YES	NO	
Limitation of mobility (i.e.: cane, wheelchair) if yes, specify	YES	NO	
Osteoporoses	YES	NO	
Osteopenia	YES	NO	
Endocrine:			
Excessive thirst	YES	NO	
Too hot/cold	YES	NO	
Tired/sluggish	YES	NO	
Integumentary:			
Skin rash	YES	NO	
Boils	YES	NO	
Persistent itch	YES	NO	
Hematologic/Lymphatic:			
Swollen gland	YES	NO	
Other	YES	NO	
Allergic/Immunologic:			
Hay Fever	YES	NO	
Other	YES	NO	
Psycho logic:			
Are you generally satisfied with life?	YES	NO	
Are you severely depressed?	YES	NO	

Men:

Are you able to achieve an erection?	YES	NO
Are you able to maintain an erection?	YES	NO

Women:

Date of Last Menstrual Period _____		
Could you be pregnant?	YES	NO
Do you take birth control pills/patches?	YES	NO
Do you take hormones?	YES	NO
Have you ever had a breast biopsy?	YES	NO
Do you have or have had breast cancer?	YES	NO
How many times have you been pregnant? _____		
How many children do you have? _____		

The above information is true and correct, and includes my entire medical history, to the best of my knowledge.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date