OREGON UROLOGY INSTITUTE

Better Options. Better Care.

Patient Medical Information

Full Name: _____ Date of Birth: _____

Reason for today's visit: _____

_____

_____

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):

_____

_____

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

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

Past Medical History Cont ~

□ Heart Attack
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol/Lipids
□ Hypothyroidism
□ 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

□ **NONE OF THE ABOVE APPLY**

Other Issues Not Listed:

_____

_____

_____

_____

Past Surgical History (Please √ 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
□ Carotid Artery Surgery
□ Cataract
□ Colon Surgery
□ Coronary Bypass
□ Coronary Stent/Heart Catheterization
□ 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
□ Shoulder Surgery
□ Spinal Fusion
□ Stomach Surgery
□ Thyroid Surgery
□ Tonsils

Urologic Surgeries:

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

□ **NONE OF THE ABOVE APPLY**

Other Surgeries Not Listed:

_____

_____

_____

Family History (Please √ 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

□ **NONE OF THE ABOVE APPLY**

Other Issues Not Listed:

_____

_____

_____

_____

Social History (Please √ your answers to the following):

□ Single
□ Married
□ Divorced
□ Widowed
□ Significant Other
□ Employed
□ Unemployed
□ Disabled
□ Retired
□ Occupation
□ Children
□ Religious Preference affecting care
□ Live at Home
□ Live in Care Facility

Risk Factors (Please √ 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: _____

Please complete back of form~

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

Allergy
□ Allergic Rash
□ Hay Fever
□ Recurrent Infections
□ Urticaria (hives)

Blood System
□ Abnormal Bruising
□ Bleeding
□ Enlarged Lymph Nodes

Cardiovascular
□ Chest Pains
□ Fainting
□ Heart Attack
□ Palpitations
□ Swelling of legs
□ Shortness of Breath
□ Shortness of Breath/Lying Down

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
□ Increased 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
□ Sleep Disorder
□ Sweats
□ Weight loss

Genitourinary
□ Blood in Urine
□ Burning with Urination
□ Decreased sex drive
□ Erectile Dysfunction
□ Incontinence
□ Urinary Frequency
□ Urinary Hesitancy
□ Abnormal Vaginal Bleeding
□ Vaginal Discharge
□ Pelvic Pain

Musculoskeletal
□ Arthritis
□ Back Pain
□ Joint Pain
□ Joint Swelling
□ 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
□ Asthma
□ Blood in Sputum
□ Chest Pain
□ Cough
□ Wheezing
□ Sleep Apnea

□ **NONE OF THE ABOVE APPLY**

Other Issues Not Listed:

_____

_____

_____

_____