

BROWARD UROLOGY
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PATIENT'S NAME: _____ **DATE:** _____

REVIEW OF SYSTEMS: (Please place a '✓' by all that apply)

<u>Allergic/Immunologic</u>	<u>Ears/Nose/Throat</u>	<u>Genitourinary</u>	<u>Musculoskeletal</u>
Seasonal	Ear Infection	Back Pain	Back Pains
Drug	Sinus Problems	Bedwetting	Joint Pains
Animal	Sore Throat	Blood in urine	Neck pain /stiffness
Environmental	Other	Dribbling	Muscle Cramps
Other	<u>Endocrine</u>	Burning on Urination	Arthritis
<u>Cardiovascular</u>	Diabetes	Erection Problems	Muscle Weakness
Chest pain/angina	Pituitary Disease	Premature Ejaculation	Other
Dyspnea on exertion	Thyroid Disease	Flank Pain	<u>Neurological</u>
Edema	Excess thirst	Hesitancy	Stroke
Hardening of the arteries	Tired/Sluggish	Kidney Failure	Headache
Heart Attack	Heat/Cold Intolerance	Kidney Infections	Dizzy spells
Heart Failure	Other	Kidney Stones	Balance problems
Heart Murmur	<u>Eyes</u>	Nocturnal Enuresis	Numbness/Tingling
High Blood Pressure	Blindness	Nocturia	Tremors
Irregular Heart beat	Blurred Vision	Prostate Infection	Leg or arm weakness
Low exercise tolerance	Double Vision	Sexual Dysfunction	Memory Loss
Mitral Valve Prolapse	Eye Pain	Low desire	Speech Problems
Orthopnea	Other	Sexually Transmitted Diseases	Other
Pain/cramps w/exercise	<u>Gastrointestinal</u>	Stranguria	<u>Psychological</u>
Palpitations	Acid Reflux	Suprapubic Pain	Not satisfied with life
Skipped Heart beats	Indigestion/Heartburn	Testes/Scrotal Swelling	Anxious
Swelling	Nausea/Vomiting	Urgency	Depressed
Other	Abdominal Pain	Urinary Frequency	Considered Suicide
<u>Constitutional</u>	Bloody Stools	Urinary Hesitancy	Other
Aches/Pains	Abdominal Cramps	Urinary Incontinence	<u>Respiratory</u>
Appetite Changes	Diarrhea	Urinary Tract Infections	Asthma
Bruises easily	Constipation	Urine Retention	Tuberculosis
Fever	Change in Bowel Habits	Urologic Cancer	Emphysema/Bronchitis
Chills	Hemorrhoids	Urologic Surgery	Environmental Allergies
Hot Flashes	Flatulence	Vaginal Bleeding	Frequent Cough
Night Sweats	Gas	Vaginal Discharge/Problems	Shortness of Breath
Fatigue	Rectal Bleeding	Weak Stream	Wheezing
Generalized Weakness	Tarry stools	Other	Other
Insomnia	Other	<u>Hematological/Lymphatic</u>	<u>Skin</u>
Swollen Glands		Swollen Glands	Acne
Anorexia		Blood clotting problems	Boils
Weight loss		Bleeding Problems	Persistent Itch
Weight gain		Hepatitis	Skin rash
Other		HIV (AIDS)	Changing moles
		IV Drug Use	Pigment changes
		Sickle Cell	Other
		Other	

Name: _____ Date: _____

PAST MEDICAL HISTORY

Please place a '✓' by any of the following diseases or conditions you have or have had:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Cholelithiasis | <input type="checkbox"/> GERD | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chronic liver disease | <input type="checkbox"/> Goiter | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic lung disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Mitral stenosis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Chronic renal insufficiency | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mitral insufficiency |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Renal Failure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Constipation | <input type="checkbox"/> Heart Valve Problem | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Colon Condition | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Congenital Heart Failure | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pancreatic Cancer |
| <input type="checkbox"/> Aortic aneurysm | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Peptic Ulcer |
| <input type="checkbox"/> Aortic Stenosis | <input type="checkbox"/> Deafness | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Aortic Insufficiency | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Impaired Glucose | <input type="checkbox"/> tol. Prostate Cancer |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Diabetes—non ins dependent | <input type="checkbox"/> Infertility | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Diabetes—insulin dependent | <input type="checkbox"/> Irritable Bowel Disease | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Diabetes—uncontrolled | <input type="checkbox"/> Inflamm. Bowel Disease | <input type="checkbox"/> Rectal Fissure |
| <input type="checkbox"/> Bi-polar disorder | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rectal Cancer |
| <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Sexually Trans. Disease |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Elevated PSA | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Brain tumors | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Laryngeal Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Enlarged Heart | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Testicular Cancer |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Fibrocystic Breast Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cerebrovascular Disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cholecystitis | <input type="checkbox"/> Gastric Cancer | <input type="checkbox"/> Lymphoma | |

SURGICAL HISTORY:

Please place a '✓' by any of the following surgeries you have had, and include the date of surgery:

Amputation	_____	Facial Surgery	_____	Orchiectomy	_____
Angioplasty	_____	Foot Surgery	_____	Pacemaker Insertion	_____
Aortic Aneurysm Repair	_____	(L or R or both)	_____	Parathyroidectomy	_____
Appendectomy	_____	Gastric Surgery	_____	Penile Implant	_____
Arthroscopic Surgery	_____	Hand Surgery	_____	PEG	_____
		(L or R or both)			
Back Surgery	_____	Heart Surgery	_____	Renal Transplant	_____
Bariatric Surgery	_____	Heart Transplant	_____	Rotator Cuff Surgery	_____
Bladder Surgery	_____	Hemorrhoidectomy	_____	Septoplasty	_____
Bowel Resection	_____	Herniorrhaphy	_____	Sinus Surgery	_____
Brachytherapy	_____	Hip Surgery	_____	Skin Grafting	_____
		Hydrocelectomy	_____		
Brain Surgery	_____	Ilioconduit	_____	Spermatocectomy	_____
Breast Surgery	_____	Ileostomy	_____	Splenectomy	_____
Biopsy of Prostate	_____	Indigo Laser Surgery	_____	Stomach Surgery	_____
CABG	_____	Inguinal Herniorrhaphy	_____	Tonsil Surgery	_____
Carotid Artery Surgery	_____	Knee Surgery	_____	Thyroid Surgery	_____
Carpal Tunnel Surgery	_____	(L or R or both)	_____		
(L or R or both)	_____	Laminectomy	_____	TMJ Surgery	_____
Cataract Surgery	_____	Laparoscopy	_____	TUMT Prostate	_____
(L or R or both)	_____	Laparotomy	_____	TUR Prostate	_____
Cervical Spine Surgery	_____	Leg Surgery	_____	Umbilical Hernia	_____
Cholecystectomy	_____	(L or R or both)	_____	Ureteroscopy	_____
Circumcision	_____	Liver Surgery	_____		
Colon Resection	_____	Lumpectomy	_____	Varicocelectomy	_____
Colonoscopy	_____	Lung Surgery	_____	Vasectomy	_____
Corneal Surgery	_____	Lymphatic Node Dissection	_____	Vein Stripping	_____
(L or R or both)	_____	Lysis Adhesions	_____	Ventral Hernia Repair	_____
Cysto-TUR Fulguration	_____	Mastectomy	_____	VLAPP	_____
Cyst Removal	_____	Mastoid Surgery	_____	OTHER NOT LISTED :	_____
Deliveries	_____	Meatotomy	_____	_____	_____
(Vaginal or C-Section)	_____	Nasal Surgery	_____	_____	_____
Ear Surgery	_____	Needle Biopsy	_____	_____	_____
(L or R or both)	_____	Nephrectomy	_____	_____	_____
EGD	_____	Nephrolithotomy	_____	_____	_____
Epididymectomy	_____				
ESWL	_____				
Eye Surgery	_____				
(L or R or both)	_____				

NAME: _____ Date: _____

FAMILY HISTORY

Please **CIRCLE** which family member has had any of the following: (Mother, Father, or Siblings)

Arthritis	M	F	S	Kidney Stones	M	F	S
Bedwetting	M	F	S	Laryngeal Cancer	M	F	S
Bladder Cancer	M	F	S	Leukemia	M	F	S
Cancer (site unknown)	M	F	S	Malignant Melanoma	M	F	S
Crohn's Disease	M	F	S	Multiple Sclerosis	M	F	S
Depression	M	F	S	Pancreatic Cancer	M	F	S
Diabetes	M	F	S	Prostate Cancer	M	F	S
Gout	M	F	S	Stroke	M	F	S
Heart Attack	M	F	S	Thyroid Disease	M	F	S
Hypertension	M	F	S	Tuberculosis	M	F	S
Kidney Disease	M	F	S	Other:	M	F	S

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicate years:

Single: _____ Married: _____ Separated: _____ Divorced: _____

Widowed: _____ Life Partner: _____ Common Law Spouse: _____

Dependants: Please indicate # of each, if you have:

Sons: _____ Daughters: _____ Stepchildren: _____ Adopted: _____ Foster: _____

Parents: _____ Grandparents: _____ Other: _____ : _____

Occupation: Please place a '✓' by one that applies:

None _____ Laborer _____ Truck Driver _____ Tradesman _____
Clerk _____ Administrative _____ Executive _____ Professional _____
Part-Time _____ Retired _____ Other _____

Hobbies: Please place a '✓' by any that apply to you:

None _____ Golf _____ Tennis _____ Computers _____ Basketball _____
Football _____ Swimming _____ Soccer _____ Baseball _____

Alcohol Consumption:

None _____ Yes - Occasional/Social _____ # of drinks per day _____

Tobacco use per day:

None _____ Yes _____ # packs/day _____ cigarettes/day _____ smokeless tobacco _____
If previously stopped, when? _____

Recreational Drugs:

None _____ If yes, please list: _____

Caffeinated beverages:

None _____ Low _____ Moderate _____ Excessive _____

Name: _____ Date: _____

ALLERGIES - Please list ALL types (Drug, seasonal, pets, environmental foods):

Recent Foreign Travel:

None: _____ Americas: _____ Worldwide: _____

CURRENT MEDICATIONS:

Please list ALL medications you are currently taking including over the counter meds

Drug Name	Strength	Directions/How you take it

(Attach list if necessary)

Pharmacy Name: _____ Phone #: _____

By what method did you choose our practice?

_____ Referring Physician _____ Friend _____ Yellow Pages _____ Insurance Co. _____ Other