

# Urology Associates of Elkhart, Inc.

Jerald A. Hochstetler, M.D.  
Anish H. Nayee, M.D.  
Timothy J. Roth, M.D.

Urologic and Genitourinary Surgeons  
Diplomates of the American Board of Urology  
Fellows of the American College of Surgeons

## Patient History Form

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

CHIEF COMPLAINT: (Reason for visit today) \_\_\_\_\_

### List Any Allergies

Dye	Y	N	Latex	Y	N
Iodine	Y	N	Shell Fish	Y	N
Medication Allergies:					
_____					
_____					
_____					
_____					

### List Any Past Surgeries

Type	Date (Year only)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### Medications (Currently Taking)

Name	Amount	Times/Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Patient's Medical History

	When Diagnosed (Year)
Diabetes Y N	_____
Heart Attack Y N	_____
Hypertension Y N	_____
Heart Murmur Y N	_____
Stroke Y N	_____
Tuberculosis Y N	_____
Asthma Y N	_____
Arthritis Y N	_____
Cancer Y N Type	_____

### Social History

Occupation: \_\_\_\_\_

Do You Smoke? Y N How Much? \_\_\_\_\_

Do You Drink Alcohol? Y N How Much? \_\_\_\_\_

### Family History

	Family Member
Cancer Y N Type	_____
Diabetes Y N	_____
Heart Disease Y N	_____
Stroke Y N	_____
Asthma Y N	_____

# Review of Systems

Do you currently have any problems related to the following systems? Circle Yes or No.

## Constitutional Systems

Fever Y N  
Chills Y N  
Headache Y N

## Gastrointestinal

Abdominal Pain Y N  
Nausea/Vomiting Y N  
Heartburn Y N

## Respiratory

Wheezing Y N  
Frequent Cough Y N  
Shortness of Breath Y N

## Eyes

Blurred Vision Y N  
Double Vision Y N  
Pain Y N

## Cardiovascular

Chest Pain Y N  
Varicose Veins Y N  
High Blood Pressure Y N

## Hematologic/Lymphatic

Swollen Glands Y N  
Blood Clotting Problems Y N

## Allergic/Immunologic

Hay Fever Y N  
Drug Allergies Y N

## Integumentary

Skin Rash Y N  
Persistent Itch Y N

## Psychological

Do you feel Depressed? Y N

## Neurologic

Tremors Y N  
Dizzy Spells Y N  
Numbness/Tingling Y N

## Musculoskeletal

Joint Pain Y N  
Neck Pain Y N  
Back Pain Y N

## Endocrine

Excessive Thirst Y N  
Too Hot/Cold Y N  
Tired/Sluggish Y N

## Ear/Nose/Throat/Mouth

Ear Infection Y N  
Sore Throat Y N  
Sinus Problems Y N

## Genitourinary

Painful Urination Y N  
Blood in Urine Y N  
Urinary Retention Y N

## Reproductive

Number of Pregnancies \_\_\_\_\_  
Number of Live Births \_\_\_\_\_

- On average, about how many times a day do you urinate? \_\_\_\_\_
- On average, how many times during the night do you urinate? \_\_\_\_\_
- During a typical day, how many protective pads do you wear?  
\_\_\_\_\_ diapers \_\_\_\_\_ maxi pads \_\_\_\_\_ panty liners
- Do you leak urine at night in bed? \_\_\_ Yes \_\_\_ No
- How often do you have such a strong urge to urinate that you expect leakage before you reach the toilet?  
\_\_\_\_\_ Often \_\_\_\_\_ Sometimes \_\_\_\_\_ Seldom \_\_\_\_\_ Never
- How often do you leak urine when you sneeze, cough, laugh, or exercise?  
\_\_\_\_\_ Often \_\_\_\_\_ Sometimes \_\_\_\_\_ Seldom \_\_\_\_\_ Never
- Which causes most of your leakage? \_\_\_ above #5 \_\_\_ above #6
- Do you have to strain to get a urine stream started? \_\_\_ Yes \_\_\_ No
- Do you feel like you empty your bladder? \_\_\_ Yes \_\_\_\_\_ No
- Have you ever had bladder kidney infections? \_\_\_ Yes \_\_\_\_\_ No
- How often do you experience pain or discomfort when you urinate?  
\_\_\_\_\_ Often \_\_\_\_\_ Sometimes \_\_\_\_\_ Seldom \_\_\_\_\_ Never
- Have you ever had surgery to correct urinary incontinence? \_\_\_ Yes \_\_\_\_\_ No
- How long have you had urinary incontinence? \_\_\_ Years \_\_\_\_\_ Months

Physician: \_\_\_\_\_

Date: \_\_\_\_\_