

Urology Associates of Elkhart, Inc.

Jerald A. Hochstetler, M.D.
 Anish H. Nayee, M.D.
 Peter C. Fretz, 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

MALE ONLY		AUA Symptom Score: Circle one number on each line				
Questions to be answered	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Over the past month, how often have you had to urinate less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month, how often have you had to push or strain to begun urination?	0	1	2	3	4	5
7. On a nightly basis, how many times do you typically get up to urinate?	0	1	2	3	4	5
Sum the seven circled numbers ((AUA Symptom Score): _____ Scoring: Mild: 0-7 Moderate: 8 to 19 Severe: 20-35						

Physician: _____

Date: _____