THE Portland Clinic®
We specialize in you.

PATIENT LABEL

PATIENT HISTORY: UROLOGY

Today's Date: _____ Date of last Physical Exam: _____ Date of Birth _____

Last Name: _____ First Name: _____ MI: _____

Chief Complaint

What is the main reason for your visit today? Please describe your problem in detail.

_____
_____
_____
_____

Physician comments/notes:

_____
_____
_____
_____
_____
_____

Past Medical History

Please list any personal illnesses:

_____
_____
_____
_____
_____

Past Surgical History

Please list surgeries and when they occurred:

_____
_____
_____
_____
_____

Please list your current medications and dosage:

_____
_____
_____
_____

Social History

Do you smoke? ❑ no ❑ yes If yes, ____ packs per day

Did you ever smoke regularly? ❑ no ❑ yes If yes, ____ for how long?

Do you drink alcohol? ❑ no ❑ yes If yes, ____ drinks per ❑ day ❑ week ❑ month

Do you drink caffeine? ❑ no ❑ yes If yes, ____ cups per ❑ day ❑ week ❑ month

Please list any drug allergies you have: _____

Family History

Please list serious illnesses in your immediate family (diabetes, tuberculosis, breast cancer, etc):

_____
_____
_____
_____
_____

Review of Systems - Do you have any problems in the following areas? Circle **Y**es or **N**o. Please explain any yes answers.

Constitutional Symptoms:

activity changes Y N _____
appetite change Y N _____
chills Y N _____
sweating Y N _____
fatigue Y N _____
fever Y N _____
other _____

Ears Nose Throat:

Facial swelling Y N _____
Neck pain Y N _____
Neck stiffness Y N _____
Ear discharge Y N _____
Hearing loss Y N _____
Ringing in ears Y N _____
Nosebleeds Y N _____
Congestion Y N _____
Runny nose Y N _____
Post nasal drip Y N _____
sneezing Y N _____
dental problem Y N _____
drooling Y N _____
mouth sores Y N _____
swallowing issues Y N _____
voice change Y N _____

Eyes:

eye discharge Y N _____
eye itching Y N _____
eye pain Y N _____
eye redness Y N _____
sensitive to light Y N _____
visual disturbance Y N _____

Respiratory:

apnea Y N _____
chest tightness Y N _____
choking Y N _____
cough Y N _____
short of breath Y N _____
wheezing Y N _____

Cardiovascular:

chest pain Y N _____
leg swelling Y N _____
palpitations Y N _____

Gastrointestinal:

bloating Y N _____
abdominal pain Y N _____
anal bleeding Y N _____
constipation Y N _____
diarrhea Y N _____
nausea Y N _____
rectal pain Y N _____
vomiting Y N _____
other Y N _____

Endocrine:

cold intolerance Y N _____
heat intolerance Y N _____
excessive thirst Y N _____
excessive hunger Y N _____
excessive urination Y N _____

Genitourinary:

difficulty urinating Y N _____
dysuria Y N _____
flank pain Y N _____
frequency Y N _____
genital sore Y N _____
blood in urine Y N _____
penile discharge Y N _____
penile pain Y N _____
scrotal swelling Y N _____
testicle pain Y N _____
urgency Y N _____
urine decreased Y N _____
weak urine stream Y N _____

Musculoskeletal:

joint pain Y N _____
back pain Y N _____
mobility issues Y N _____
joint swelling Y N _____
muscle pain Y N _____

Skin:

Color change Y N _____
Pallor Y N _____
Rash Y N _____
Wound Y N _____

Allergy/Immunologic:

seasonal allergies Y N _____
food allergies Y N _____
immunocompromisied Y N _____

Neurological:

Dizziness Y N _____
facial assymetry Y N _____
headaches Y N _____
light headed Y N _____
numbness Y N _____
seizures Y N _____
speech difficulty Y N _____
fainting Y N _____
tremors Y N _____
weakness Y N _____

Hematologic:

enlarged lymph nodes Y N _____
bruises/bleeds easily Y N _____
other _____