The Portland Clinic

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? Check Yes or No. Please explain any yes answers.

Constitutional Symptoms:

Activity changes	❑ No ❑ Yes	_____
Appetite change	❑ No ❑ Yes	_____
Chills	❑ No ❑ Yes	_____
Sweating	❑ No ❑ Yes	_____
Fatigue	❑ No ❑ Yes	_____
Fever	❑ No ❑ Yes	_____
Other		_____

Ears Nose Throat:

Facial swelling	❑ No ❑ Yes	_____
Neck pain	❑ No ❑ Yes	_____
Neck stiffness	❑ No ❑ Yes	_____
Ear discharge	❑ No ❑ Yes	_____
Hearing loss	❑ No ❑ Yes	_____
Ringing in ears	❑ No ❑ Yes	_____
Nosebleeds	❑ No ❑ Yes	_____
Congestion	❑ No ❑ Yes	_____
Runny nose	❑ No ❑ Yes	_____
Post nasal drip	❑ No ❑ Yes	_____
Sneezing	❑ No ❑ Yes	_____
Dental problem	❑ No ❑ Yes	_____
Drooling	❑ No ❑ Yes	_____
Mouth sores	❑ No ❑ Yes	_____
Swallowing issues	❑ No ❑ Yes	_____
Voice change	❑ No ❑ Yes	_____

Eyes:

Eye discharge	❑ No ❑ Yes	_____
Eye itching	❑ No ❑ Yes	_____
Eye pain	❑ No ❑ Yes	_____
Eye redness	❑ No ❑ Yes	_____
Sensitive to light	❑ No ❑ Yes	_____
Visual disturbance	❑ No ❑ Yes	_____

Respiratory:

Apnea	❑ No ❑ Yes	_____
Chest tightness	❑ No ❑ Yes	_____
Choking	❑ No ❑ Yes	_____
Cough	❑ No ❑ Yes	_____
Short of breath	❑ No ❑ Yes	_____
Wheezing	❑ No ❑ Yes	_____

Cardiovascular:

Chest pain	❑ No ❑ Yes	_____
Leg swelling	❑ No ❑ Yes	_____
Palpitations	❑ No ❑ Yes	_____

Gastrointestinal:

Bloating	❑ No ❑ Yes	_____
Abdominal pain	❑ No ❑ Yes	_____
Anal bleeding	❑ No ❑ Yes	_____
Constipation	❑ No ❑ Yes	_____
Diarrhea	❑ No ❑ Yes	_____
Nausea	❑ No ❑ Yes	_____
Rectal pain	❑ No ❑ Yes	_____
Vomiting	❑ No ❑ Yes	_____
Other		_____

Endocrine:

Cold intolerance	❑ No ❑ Yes	_____
Heat intolerance	❑ No ❑ Yes	_____
Excessive thirst	❑ No ❑ Yes	_____
Excessive hunger	❑ No ❑ Yes	_____
Excessive urination	❑ No ❑ Yes	_____

Genitourinary:

Difficulty urinating	❑ No ❑ Yes	_____
Dysuria	❑ No ❑ Yes	_____
Flank pain	❑ No ❑ Yes	_____
Frequency	❑ No ❑ Yes	_____
Genital sore	❑ No ❑ Yes	_____
Blood in urine	❑ No ❑ Yes	_____
Penile discharge	❑ No ❑ Yes	_____
Penile pain	❑ No ❑ Yes	_____
Scrotal swelling	❑ No ❑ Yes	_____
Testicle pain	❑ No ❑ Yes	_____
Urgency	❑ No ❑ Yes	_____
Urine decreased	❑ No ❑ Yes	_____
Weak urine stream	❑ No ❑ Yes	_____

Musculoskeletal:

Joint pain	❑ No ❑ Yes	_____
Back pain	❑ No ❑ Yes	_____
Mobility issues	❑ No ❑ Yes	_____
Joint swelling	❑ No ❑ Yes	_____
Muscle pain	❑ No ❑ Yes	_____

Skin:

Color change	❑ No ❑ Yes	_____
Pallor	❑ No ❑ Yes	_____
Rash	❑ No ❑ Yes	_____
Wound	❑ No ❑ Yes	_____

Allergy/Immunologic:

Seasonal allergies	❑ No ❑ Yes	_____
Food allergies	❑ No ❑ Yes	_____
Immunocompromised	❑ No ❑ Yes	_____

Neurological:

Dizziness	❑ No ❑ Yes	_____
Facial asymmetry	❑ No ❑ Yes	_____
Headaches	❑ No ❑ Yes	_____
Light headed	❑ No ❑ Yes	_____
Numbness	❑ No ❑ Yes	_____
Seizures	❑ No ❑ Yes	_____
Speech difficulty	❑ No ❑ Yes	_____
Fainting	❑ No ❑ Yes	_____
Tremors	❑ No ❑ Yes	_____
Weakness	❑ No ❑ Yes	_____

Hematologic:

Enlarged lymph nodes	❑ No ❑ Yes	_____
Bruises/bleeds easily	❑ No ❑ Yes	_____
Other		_____