PHYSICIANS' CLINIC
of Iowa, P.C.

UROLOGY HISTORY FORM

Today's Date _____ First Name _____ Last Name _____

Date of Birth _____ Age _____ Gender: ☐ Male ☐ Female Family Physician _____

Height _____ Weight _____ Do you consume caffeine? ☐ Yes ☐ No If yes, how much per day? _____

Main reason for your visit _____

_____

List recent tests/x-rays: _____

List any changes to your health history since your last visit: _____

UROLOGICAL HISTORY

Do you see blood in your urine? ☐ Yes ☐ No

Do you urinate frequently during the day? ☐ Yes ☐ No

If yes, how often? _____

Do you urinate at night? ☐ Yes ☐ No

If yes, how many times per night? _____

Do you have any incontinence? ☐ Yes ☐ No
(Lose control of your urine or wet your pants.)

With coughing or lifting? ☐ Yes ☐ No

With urgency to urinate? ☐ Yes ☐ No

Do you have trouble starting your urine stream? ☐ Yes ☐ No

Do you have a slow urine stream? ☐ Yes ☐ No

Do you have urgency to urinate? ☐ Yes ☐ No

Have you ever had a kidney stone? ☐ Yes ☐ No

Have you ever had a bladder stone? ☐ Yes ☐ No

Do you get bladder infections? ☐ Yes ☐ No

If yes, how often? _____

If yes, how many bladder infections have you had in the past year? _____

Do you have Glaucoma? ☐ Yes ☐ No

Do you have Macular Degenerative Disease? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

FOR MEN ONLY

Are you able to obtain an erection? ☐ Yes ☐ No

Are you able to maintain an erection? ☐ Yes ☐ No

Do you have painful ejaculation? ☐ Yes ☐ No

Have you had a previous PSA? ☐ Yes ☐ No

If yes, where was the test done? _____

FOR WOMEN ONLY

Are you currently pregnant? ☐ Yes ☐ No

Have you reached menopause? ☐ Yes ☐ No

If yes, when? _____

REVIEW OF SYSTEMS: Please check any new symptoms you have experienced in the last MONTH.

Constitutional/General
☐ Yes ☐ No Fever
☐ Yes ☐ No Chills
☐ Yes ☐ No Heavy Sweating/ Night Sweats
☐ Yes ☐ No Loss of Appetite
☐ Yes ☐ No Sleep Disturbances
☐ Yes ☐ No Unexplained Weight Loss/Gain
☐ Other: _____

Eyes
☐ Yes ☐ No Blurry Vision
☐ Yes ☐ No Double Vision
☐ Yes ☐ No Wear Glasses
☐ Other: _____

Ear/Nose/Throat
☐ Yes ☐ No Sore Throat
☐ Yes ☐ No Mouth Sores
☐ Yes ☐ No Nasal Congestion/ Sinus Issues
☐ Yes ☐ No Hearing Loss
☐ Other: _____

Respiratory
☐ Yes ☐ No Cough
☐ Yes ☐ No COPD
☐ Yes ☐ No Wheezing
☐ Yes ☐ No Recurrent Respiratory Infections
☐ Yes ☐ No Shortness of Breath
☐ Other: _____

Cardiovascular
☐ Yes ☐ No Chest Pain or Discomfort
☐ Yes ☐ No Swelling Feet, Ankles, Legs
☐ Yes ☐ No Irregular Heartbeat
☐ Yes ☐ No Heart Attack
☐ Yes ☐ No Palpitations
☐ Yes ☐ No Varicose Veins
☐ Other: _____

Gastrointestinal
☐ Yes ☐ No Abdominal Pain
☐ Yes ☐ No Nausea/Vomiting
☐ Yes ☐ No Indigestion/Heartburn
☐ Yes ☐ No Blood in Stools
☐ Yes ☐ No Change in Bowel Habits
☐ Yes ☐ No Rectal Bleeding
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Constipation
☐ Yes ☐ No Loss of Bowel Control
☐ Yes ☐ No Swallowing Difficulties
☐ Other: _____

Gynecological
☐ Yes ☐ No Vaginal Dryness
☐ Yes ☐ No Painful/Irregular Periods
☐ Yes ☐ No Painful Intercourse
☐ Yes ☐ No Pelvic Pain
☐ Yes ☐ No Prolapse
☐ Yes ☐ No Able to Have Orgasm
☐ Yes ☐ No Painful Orgasm
☐ Yes ☐ No Pain with Tampon Use
☐ Yes ☐ No Pain With Exam
☐ Other: _____

Psychological
☐ Yes ☐ No Depression
☐ Yes ☐ No Anxiety
☐ Other: _____

Genitourinary
☐ Yes ☐ No Painful Urination
☐ Yes ☐ No Urinary Frequency
☐ Yes ☐ No Loss of Urinary Control
☐ Yes ☐ No Enlarged Prostate
☐ Yes ☐ No Difficulty Urinating
☐ Other: _____

Skin
☐ Yes ☐ No Skin Rash
☐ Yes ☐ No Itching
☐ Yes ☐ No Discoloration
☐ Yes ☐ No Lumps or Masses
☐ Other: _____

Musculoskeletal
☐ Yes ☐ No Joint Pain
☐ Yes ☐ No Joint Swelling
☐ Yes ☐ No Back Pain
☐ Yes ☐ No Limitation of Motion
☐ Yes ☐ No Neck Pain
☐ Yes ☐ No Pain with Walking
☐ Other: _____

Endocrine
☐ Yes ☐ No Excessive Thirst/ Fluid Intake
☐ Yes ☐ No Temperature Intolerance
☐ Yes ☐ No Feeling Tired (Fatigue)
☐ Yes ☐ No Hot Flashes
☐ Other: _____

Continued on next page →

Hematologic/Lymphatic

☐ Yes ☐ No Swollen Glands
☐ Yes ☐ No Blood Clotting Problem
☐ Yes ☐ No Easy Bruising
☐ Yes ☐ No Bleeding Tendencies
☐ Other: _____

Neurological

☐ Yes ☐ No Tremors
☐ Yes ☐ No Dizzy Spells
☐ Yes ☐ No Numbness/Tingling
☐ Yes ☐ No Headache
☐ Yes ☐ No Unsteady Gait
☐ Yes ☐ No Feeling Weak
☐ Yes ☐ No Convulsions/Seizures
☐ Other: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

This form is destroyed after the information is entered and verified in the patient's electronic health record.