

**Urology Associates of Danbury, P.C.**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Chief Complaint: What is the main reason for your visit today?  
\_\_\_\_\_  
\_\_\_\_\_

**History of Present Illness:**

On scale of 1 to 10, with 10 being the most severe, circle the number that best describes the severity of the problem:  
1 2 3 4 5 6 7 8 9 10

How long ago did you first notice the problem? \_\_\_\_\_

	Yes	No
Does anything help the problem?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Moving Around		
<input type="checkbox"/> Standing Up		
<input type="checkbox"/> Lying on My Side		
<input type="checkbox"/> Other _____		

Does anything make the problem worse?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Moving Around		
<input type="checkbox"/> Standing Up		
<input type="checkbox"/> Lying on my Side		
<input type="checkbox"/> Other		

How long does the problem last?

- 30 Minutes
- One Hour
- It is Always There
- Other \_\_\_\_\_

Is there anything else occurring at the same time?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain:		
<input type="checkbox"/> Nausea		
<input type="checkbox"/> Rash		
<input type="checkbox"/> Burning on Urination		
<input type="checkbox"/> Blood in Urine		
<input type="checkbox"/> Other		

Is the problem:       Constant   -or-    Variable?

- Dull, then sharp
- Very sharp, then leaves
- Always there
- Other \_\_\_\_\_

Does the problem interfere with your normal functions?	Yes	No
If yes, please explain: _____		
_____		

*(Please complete both sides)*

Patient Name \_\_\_\_\_

List Medical Problems: (Please list any chronic illnesses, past surgeries or hospitalizations)

- |                     |                          |                   |                          |
|---------------------|--------------------------|-------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | Heart Murmur      | <input type="checkbox"/> |
| Diabetes            | <input type="checkbox"/> | Valve Replacement | <input type="checkbox"/> |
| Heart Problems      | <input type="checkbox"/> | Joint Replacement | <input type="checkbox"/> |
| Asthma              | <input type="checkbox"/> | Afibrillation     | <input type="checkbox"/> |
| Glaucoma            | <input type="checkbox"/> | Coronary Disease  | <input type="checkbox"/> |

Other (Please list): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Hospitalizations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Surgeries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

.....  
**Social History:**

Do/did you smoke: Yes No How much \_\_\_\_\_ No. of years \_\_\_\_\_ When did you stop \_\_\_\_\_  
Number of Alcoholic Beverages per week \_\_\_\_\_  
Occupation: \_\_\_\_\_

**Family History:** Does anyone in your family have?

	Yes	No	Who
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Name: \_\_\_\_\_

## Review of Systems

Do you experience any of the following?

### Constitutional:

- Fever
- Chills
- Fatigue
- Weakness
- Weight loss
- Weight gain
- Other: \_\_\_\_\_

### Eyes:

- Glaucoma
- Double vision
- Blurred vision
- Poor vision
- Eye pain
- Other: \_\_\_\_\_

### Ear/Nose/Throat:

- Nose bleeds
- Sore throats
- Sinus problems
- Difficulty hearing
- Earaches
- Other \_\_\_\_\_

### Cardiovascular:

- High blood pressure
- Need to sleep with head elevated
- Short of breath walking
- Chest pain
- Irregular heart beat
- Palpitation
- Swelling of legs or ankles

### Respiratory:

- Wheezing
- Shortness of breath
- Cough
- Other: \_\_\_\_\_

### Gastrointestinal:

- Diarrhea
- Change in bowel habits
- Abdominal pain
- Nausea/vomiting
- Heartburn/indigestion
- Blood in stool
- Constipation
- Other \_\_\_\_\_

Patient Name: \_\_\_\_\_

**Genitourinary:**

- Burning on urination
- Unusual urgency to urinate
- Difficulty getting urine started
- Getting up at night to urinate
- Urinary tract infection
- Leaking urine
- Blood in urine

**Musculoskeletal**

- Bone pain
- Joint swelling
- Joint stiffness
- Joint pain
- Other: \_\_\_\_\_

**Neurological:**

- Seizures
- Dizziness
- Weakness
- Headache
- Numbness
- Other: \_\_\_\_\_

**Endocrine:**

- Tired or sluggish
- Excessive thirst
- Too hot or cold
- Hot flashes
- Weight loss
- Other: \_\_\_\_\_

**Skin:**

- Rash
- Hives
- Skin cancer
- Other: \_\_\_\_\_

**Psychologic:**

- Depression
- Trouble sleeping
- Anxiety
- Other: \_\_\_\_\_

**Allergic/Immunologic:**

- Hay fever
- Food allergies
- Latex allergy

**Hematologic/Lymphatic:**

- Anemia
- Taking blood thinners
- Blood Clotting
- Easy bruising
- Swollen glands
- Other: \_\_\_\_\_