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

**History of Present Illness**

<table>
<thead>
<tr>
<th>Location of the problem:</th>
<th>Abdomen</th>
<th>Back</th>
<th>Groin</th>
<th>Bladder</th>
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</thead>
<tbody>
<tr>
<td>Other</td>
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On a scale of 1-10, with 10 being the most severe,

What number best describes the problem? ________________

When did you first notice the problem? ________________

Does anything make the problem worse? □ Moving About □ Standing Up

□ Urinating □ Other ________________

Does anything help make the problem better? □ Change Posture □ Not Moving

□ Other ________________

Are there any treatments that your doctor would provide that are prohibited by your religious beliefs? □ No □ Yes If Yes, Please explain.

Have the symptoms changed over time? □ No □ Yes If Yes, Please explain.

How long does the problem last? □ ______ Minutes □ ______ Hours □ Constant

□ Other ________________

Is anything occurring at the same time? □ No □ Yes If Yes, Please explain.

Is the problem constant? □ No □ Yes If not, please describe.

Does the problem interfere with your normal function? □ No □ Yes If Yes, Please explain.

**Past Medical, Social History, Family History**

**Allergies:** □ No drug allergies □ Latex

**Surgery History:** Type / Date □ None

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<th>Type / Date</th>
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Have you had a blood transfusion? □ No □ Yes Artificial heart valve? □ No □ Yes

Artificial joint? □ No □ Yes Antibiotic prophylaxis required? □ No □ Yes

Cardiac stent? □ No □ Yes Date __________

**Medical History:** List any past or current illness and start date: □ None

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<tr>
<th>Condition and start date</th>
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**Family History:** Condition, relationship (list any serious conditions in your immediate family: e.g., diabetes, heart disease, kidney disease, kidney stones, prostate cancer, etc.): □ None

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**Medications/herbs/supplements:** name, dosage, instructions —

(e.g., Flomax 0.4mg once daily) □ None
Medications/herbs/supplements (continued):

Date of last physical examination

What is your Height? _____ ft. _____ in. What is your Weight? _____ lbs.

Smoking History

- Never Smoked
- Former Smoker
- Current Smoker
- Current Some Day Smoker
- Started Smoking

- Stopped Smoking

- Amt: Day  Week

Chew Dip tobacco

- Amt:  Day  Week

Do you drink alcohol?

- Yes
- Not anymore
- Never

Drinks per

- Day
- Week
- Month
- Year

Type:

- Beer
- Liquor
- Wine

Present Or Prior Drinking Habits:

- Social
- Light

- Moderate
- Excessive

- Quit (year) Drank how long? Years

How much caffeine do you consume daily?

- Cups coffee
- Cups tea

- # Sodas
- # Power drinks
- Other

Type and amt. chocolate

Review of Symptoms:

Within the past six months, any problems with any of the following? If, yes, please explain.

- None

Any: Fever, chills, or weight loss?

- No
- Yes

Any: Blurry vision, Double Vision, or Cataracts?

- No
- Yes

- Any: Hearing Loss, Stuffy Nose, or Sore Throat?

- No
- Yes

- Any: Chest Pain, Swollen Ankles, or Irregular Heart Beats?

- No
- Yes

- Any: Shortness of Breath, Wheezing, or Chronic Cough?

- No
- Yes

- Any: Stomach Pain, Nausea/Vomiting, or Bowel Changes?

- No
- Yes

- Any: Back Pain, Neck Pain, or Sore Muscles?

- No
- Yes

- Any: Rash, Itching, or History of Skin Cancer?

- No
- Yes

- Any: Swollen Glands, Bleeding, or Transfusions?

- No
- Yes

All Patients:

It is the responsibility of the patient to notify this office of pre-admission and/or second opinion requirements of their insurance company at the time of scheduling hospital admissions or surgery. I hereby authorize the release of any medical information pertinent to my care to my referring physician/family physician and insurance companies and accept responsibility for payment of all medical/surgical fees. I also authorize payment of insurance benefits to Associated Urologists of North Carolina, PA, except when the amount has been paid in full by me.

Signed

Print name

Date

Medicare Patients:

I request that payment under the Medicare Insurance Program be made directly to Associated Urologists of North Carolina, PA, on any bills for service furnished by their physicians during my lifetime. I understand that I may be held responsible for a portion of these bills after Medicare has paid the provider, or for any charges that Medicare does not cover.

Signed

Print name

Date