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PATIENT HISTORY FORM

Please fill in the entire form if you are a new patient or have not been seen in over 1 year, otherwise fill in the shaded areas only

Today's Date _____ / _____ / _____ S.S.N. # _____
 Last Name _____ First Name _____ Phone _____
 Date of Birth _____ / _____ / _____ Age _____ Referring Physician _____

CHIEF COMPLAINT: _____

HISTORY OF PRESENT ILLNESS:

When did it begin: _____
 Describe pain (if any): _____
 Is it getting worse: Y N
 Is it associated with anything else: _____

PAST MEDICAL HISTORY:
 Past Surgery With Dates: _____

MEDICAL PROBLEMS:

Kidney disease (and/or stones):	Y	N	_____
Heart disease:	Y	N	_____
Liver disease:	Y	N	_____
Lung disease:	Y	N	_____
Diabetes:	Y	N	_____
High blood pressure:	Y	N	_____
Gastrointestinal problems:	Y	N	_____
Neurological problems:	Y	N	_____
Orthopedic problems	Y	N	_____

M.D. NOTES

List all medications: _____
 Allergies to Drugs: _____

SOCIAL HISTORY:

Tobacco: Y N How Much _____
 Alcohol: Y N How Much _____
 Occupation: _____

FAMILY HISTORY: Health status

Mother: _____
 Father: _____
 Family Hx of prostate cancer: Y N

REVIEW OF SYSTEM: (Have you experienced any of the following):

Genitourinary:

Nighttime urination	Y	N
Blood in urine	Y	N
Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Recurrent infections	Y	N
Other: _____		

Neurological:

Tremors:	Y	N
Dizzy Spells/Murmur	Y	N
Numbness/Tingling	Y	N
Other: _____		

Respiratory:

Wheezing:	Y	N
Frequent cough:	Y	N
Shortness of breath:	Y	N
Other: _____		

Gastrointestinal:

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Other: _____		

Musculoskeletal:

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other: _____		

Cardiovascular:

Chest pain	Y	N
Palpitations/Murmur	Y	N
Other: _____		

Allergy:

Medication	Y	N
Food	Y	N
Other: _____		

Ear/Nose/Throat/Mouth:

Ear infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other: _____		

Eyes:

Blurred vision	Y	N
Double vision	Y	N
Corrective lenses	Y	N
Other: _____		

Skin:

Rashes	Y	N
Hives	Y	N
Eczema/Psoriasis	Y	N
Other: _____		

FOR OFFICE USE ONLY

PHYSICAL EXAM

CONSTITUTIONAL (Any three of the following seven vital signs)

- Sitting or Standing B/P _____
- Supine B/P _____
- Pulse Rate & Regularity _____
- Respiration _____
- Temperature _____
- Height _____
- Weight _____

GASTROINTESTINAL (Abdomen)

- Presence of masses/tenderness _____
- Presence/Absence of Hernia _____
- Liver & Spleen Exam _____
- Stool sample (for Occult Blood when necessary) _____

MALE: (All elements identified by bullets)

GENTOURINARY (SINGLE SYSTEM)

- Inspection of anus and perineum _____

Examination of genitalia including:

- Scrotum (eg, lesions, cysts, rashes) _____
- Epididymides (eg, size, symmetry, masses) _____
- Testes (eg, size, symmetry, masses) _____
- Urethral meatus (eg, size, location, lesions, discharge) _____
- Penis (eg, lesions, presence or absence of foreskin, foreskin, foreskin retractability, plaque, masses, scarring, _____

Digital rectal examination including:

- Prostate gland (eg, size, symmetry, nodularity, tenderness) _____
- Seminal vesicles (eg, symmetry, tenderness, masses, enlargement) _____
- Sphincter tone, presence of hemorrhoids, rectal masses _____
- Inspection of palpation of breasts _____

FEMALE: (Includes at least seven of the following eleven elements identified by bullets)

- Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses _____

Pelvic examination, including:

- External genitalia (eg, general appearance, hair distribution, lesions) _____
- Urethra (eg, size, location, lesions, prolapse) _____
- Bladder (eg, fullness, masses, tenderness) _____
- Vagina (eg, general appearance, estrogen effect, discharge lesions, pelvic support, cystocele, rectocele) _____
- Cervix (eg, general appearance, lesions, discharge) _____
- Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support) _____
- Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity) _____
- Anus and perineum _____

U/A:

X-RAY:

CYSTO:

Dictated: Y N

IMPRESSION:

RX:

FOLLOW UP:

M.D. SIGNATURE: _____