

Urologic Institute of New Jersey

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Consultation

Patient Name: _____ DOB _____ Date _____

Telephone: _____ Referred By _____

HPI(Location, Duration, Timing, Quality, Severity, Modifying Factors, Associated Symptoms)

- 1) _____

- 2) _____

- 3) _____

Review of systems: Circle present symptoms

Const: Fever Chills Fatigue Weight Change
Eyes: Vision Change Dry Eyes
Heart: Chest Pain Palpitations swelling in legs
Resp: Cough Wheeze Short of Breath
GI: Abd pain Nausea Vomiting Diarrhea
Constipation, Blood in stool tarry stool
MS: Pain Stiffness Joint/Back
H-L: Bleeding Clotting Problems
Endo: Thirst Heat/Cold intolerance/ Night Sweats
Skin: Rash Lesions Ulcers
Neuro: Headaches Dizziness

Urologic ROS (Please circle present symptoms)

- Decreased urine Flow Post-voiding dribbling
- Sense of incomplete emptying
- Frequent voiding Urge to urinate often
- Getting up at nights to urinate
- Leaking urine during cough, sneeze
- Leaking urine without warning
- Blood in Urine (seen/told by doctor)
- Stones in Kidney/Bladder
- Infection in Bladder/Kidney
- Problems with getting/maintain erections
- Problems with sexual desire
- Loss of morning Erections

Family History

- Kidney/Bladder/Prostate Cancer
- Kidney Stones
- Enlarged Prostate
- Diabetes/High Blood Pressure/Heart Disease

Past Surgical History

Past Medical History

Past Urologic History

Social History

Smoker Y/N Ex-Smoker Y/N
Alcohol Y/N Daily/Socially
Occupation: Working/Retired

Allergies Y/N

Medications N/Y

