Bedford Regional
UROLOGY
We Get You Going

UROLOGY HISTORY FORM

Today's Date: ____________ First Name: ____________ Last Name: ____________

Date of Birth: ____________ Age: ____________ Gender: M F 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: ____________

Previous surgeries: ____________ Medications: ____________

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

UROLOGY HISTORY		
Do you see blood in your urine?	Yes	No
Do you urinate frequently during the day? If yes, how often? ____________	Yes	No
Do you urinate at night? If yes, how many times per night? ____________	Yes	No
Do you have trouble starting your urine stream?	Yes	No
Do you have urgency to urinate?	Yes	No
Have you ever had a bladder stone?	Yes	No
Do you have Glaucoma?	Yes	No
Do you have Macular Degenerative Disease?	Yes	No
Do you have a slow urine stream?	Yes	No
Have you ever had a kidney stone?	Yes	No
Do you have incontinence? (Loss of control of your urine or wet your pants.) With coughing or lifting? Yes No With urgency to urinate? Yes No	Yes	No
Do you get bladder infections? If yes, how often? ____________ If yes, how many bladder infections have you had in the past year? ____________	Yes	No

FOR MEN ONLY		
Are you able to obtain an erection?	Yes	No
Are you able to maintain an erection?	Yes	No
Have you had a previous PSA? If yes, where was the test done? ____________	Yes	No

FOR WOMEN ONLY		
Are you currently pregnant?	Yes	No

REVIEW OF SYMPTOMS: PLEASE CHECK ANY NEW SYMPTOMS YOU HAVE EXPERIENCED IN THE LAST MONTH.

CONSTITUTIONAL/GENERAL
- Fever
- Chills
- Heavy Sweating/Night Sweats
- Loss of Appetite
- Sleep Disturbances
- Unexplained Weight Loss/Gain
- Other: ____________

EYES
- Blurry Vision
- Double Vision
- Wear Glasses
- Other: ____________

EAR/NOSE/THROAT
- Sore Throat
- Mouth Sores
- Nasal Congestion/Sinus Issues
- Hearing Loss
- Other: ____________

RESPIRATORY
- Cough
- COPD
- Wheezing
- Recurrent Respiratory Infections
- Shortness of Breath
- Other: ____________

CARDIOVASCULAR
- Chest Pain or Discomfort
- Swelling Feet, Ankles, Legs
- Irregular Heartbeat
- Heart Attack
- Palpitations
- Varicose Veins
- Stents: Placed when? ____________

PSYCHOLOGICAL
- Depression
- Anxiety
- Other: ____________

GASTROINTESTINAL
- Abdominal Pain
- Nausea/Vomiting
- Indigestion/Heartburn
- Blood in Stools
- Change in Bowel Habit
- Rectal Bleeding
- Diarrhea
- Constipation
- Swallowing Difficulties
- Other: ____________

GENITOURINARY
- Painful Urination
- Urinary Frequency
- Loss of Urinary Control
- Enlarged Prostate
- Difficulty Urinating
- Other: ____________

SKIN
- Skin Rash
- Itching
- Discoloration
- Lumps or Masses
- Other: ____________

HEMATOLOGIC/LYMPHATIC
- Swollen Glands
- Blood Clotting Problem
- Easy Bruising
- Bleeding Tendencies
- Other: ____________

ENDOCRINE
- Excessive Thirst/Fluid Intake
- Temperature Intolerance
- Feeling Tired (Fatigue)
- Hot Flashes
- Other: ____________

MUSCULOSKELETAL
- Joint Pain
- Joint Swelling
- Back Pain
- Limitation of Motion
- Neck Pain
- Pain with Walking
- Other: ____________

NEUROLOGICAL
- Tremors
- Dizzy Spells
- Numbness/Tingling
- Headache
- Unsteady Gait
- Feeling Weak
- Convulsions/Seizures
- Other: ____________

Patient Signature: ____________ Date: ____________

Provider Signature: ____________ Date: ____________

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