Maine Medical Partners - Urology
a department of Maine Medical Center

Patient Name:	Date of Birth

HISTORY OF PRESENT ILLNESS

CHIEF COMPLAINT (Please describe in detail the primary reason for your visit today)

Location of the problem (circle all that apply)
Bladder Right flank Left Flank Abdomen Penis Right Testicle Left Testicle Scrotum Groin Back Pelvis
Other (describe):

When did you first notice the problem?

What is the nature of these symptoms?
Burning Aching Sharp Dull Numb Throbbing Other:

Are symptoms constant, or do they come and go (circle)? Always there Come and go

What makes the problem worse? Activity Urination Bowel Movement Eating Standing Other:

What makes the problem better? Activity Urination Bowel Movement Eating Standing Rest Other:

How long does the problem last?

Do any other symptoms occur at the same time? Yes No
Rash Headache Nausea Vomiting Fever Chills Sweats Change in bowel habit Blood in urine
Other (describe):

Do these symptoms/problems interfere with your normal functioning? Yes No

MEDICAL HISTORY

Please answer Yes or No to the following questions about your medical history

	Yes	No		Yes	No		Yes	No
Kidney Cancer			Kidney Stones			Kidney Disease		
Bladder Cancer			Recurring Urinary Tract infections			Use of CPAP machine		
Prostate Cancer			Elevated PSA			Erectile dysfunction		
Testicular Cancer			Blood Clotting Disorder			Arthritis		
Cancer (specify below)			Mental Health Problems			Seizures		
Diabetes			Thyroid Disease			Nerve/Muscle Disease		
Heart Disease			High Cholesterol			High Blood Pressure		

Other History (list)

SURGICAL HISTORY

Please answer Yes or No to the following questions about your surgical history

	Yes	No		Yes	No		Yes	No
Kidney Surgery			Bladder Surgery			Prostate Surgery		
Prostate Biopsy			Lithotripsy/Stone Surgery			Testicle Surgery		
Colon Surgery			Back/Spinal Surgery			Heart Surgery		
Cancer (other) Surgery			Do you require antibiotics before dental procedure or surgery?			Hernia Repair		

Other Surgery (list)

SOCIAL HISTORY

Tobacco Use (circle)	Yes Never Quit Passive exposure		
Packs per day #	**years smoking #**	**Quit Date**	
Alcohol Use	Yes	No	**Number of drinks/week**
Sexually Active	Yes	No	Not Currently Active
Partners	Female	Male	
Special Diet? (Circle)	Low Salt Low Fat Low Sugar/Diabetic Restricted Fluid Other		
Marital Status (circle)	Single Married/partner Divorced/Separated Other:		
Occupation (describe)			

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PATIENT NAME: **DATE OF BIRTH:**

REVIEW OF SYMPTOMS

Please answer each question by circling a Yes or No response.
Leave question blank and request help if you are unsure or don't understand.

Constitutional			Eyes			Gastrointestinal			Endo/Heme/Allergy		
Fever	Yes	No	Blurred vision	Yes	No	Heartburn	Yes	No	Easy bruise/bleed	Yes	No
Chills	Yes	No	Double vision	Yes	No	Nausea	Yes	No	Environment allergies	Yes	No
Weight loss	Yes	No	Light sensitivity	Yes	No	Vomiting	Yes	No	Excessive thirst	Yes	No
Malaise/Fatigue	Yes	No	Eye pain	Yes	No	Stomach pain	Yes	No	**Neurological**		
Excessive Sweating	Yes	No	Eye Discharge	Yes	No	Diarrhea	Yes	No	Dizziness	Yes	No
Weakness	Yes	No	Eye Redness	Yes	No	Constipation	Yes	No	Tingling	Yes	No
Skin			**Heart/Circulation**			Blood in stool	Yes	No	Tremor	Yes	No
Rash	Yes	No	Chest pain	Yes	No	**Genitourinary**			Sensory change	Yes	No
Itching	Yes	No	Palpitations	Yes	No	Pain/Burning with urination	Yes	No	Speech change	Yes	No
Head & Throat			Difficulty breathing (while lying down)	Yes	No	Urgency	Yes	No	One-sided weakness	Yes	No
Headaches	Yes	No	"Heavy feeling" legs	Yes	No	Frequency	Yes	No	Seizures	Yes	No
Hearing Loss	Yes	No	Leg swelling	Yes	No	Blood in urine	Yes	No	Loss of consciousness	Yes	No
Ringing in ears	Yes	No	**Respiratory**			Flank pain	Yes	No	**Psychiatric**		
Ear pain	Yes	No	Cough	Yes	No	**Musculoskeletal**			Depression	Yes	No
Ear discharge	Yes	No	Cough blood	Yes	No	Muscle pain	Yes	No	Suicidal ideas	Yes	No
Nosebleeds	Yes	No	Sputum production	Yes	No	Neck pain	Yes	No	Substance abuse	Yes	No
Congestion	Yes	No	Shortness of breath	Yes	No	Back pain	Yes	No	Hallucinations	Yes	No
Loud breathing	Yes	No	Wheezing	Yes	No	Joint pain	Yes	No	Nervous/Anxiety	Yes	No
Sore throat	Yes	No				Falls/poor balance	Yes	No	Trouble sleeping	Yes	No
									Memory loss	Yes	No

I have carefully reviewed all questions, and all answers are "NO" except those specifically checked "Yes"

FAMILY HISTORY

	Still Living ? (Circle)		CANCER: Kidney (Renal)	Bladder	Prostate	Lung	Breast	Other	OTHER DISEASES/DISORDERS: Dia-betes	Mental Illness	Heart Disease	Depres-sion	Genito - Urinary
Mother	Yes	No											
Father	Yes	No											
Maternal Grandmother	Yes	No											
Maternal Grandfather	Yes	No											
Paternal Grandmother	Yes	No											
Paternal Grandfather	Yes	No											
Brother	Yes	No											
Brother	Yes	No											
Sister	Yes	No											
Sister	Yes	No											