NORTH CENTRAL TEXAS
UROLOGY
Treating the Whole Family

Patient's Name: _____

DOB: _____ App't Date: _____

MEDICAL HISTORY

Current Medications List all medications you currently take including vitamins, herbal supplements and over-the-counter medications. If needed, attach an additional sheet.

Medication	Indication	Dosage	Frequency You Take It	Start Date

☐ **I authorize this office to have access to my prescription drug history.** Patient Signature: _____

Allergies List any medical or environmental allergies you have.

_____ ☐ None

Labs & Imaging List any recent laboratory or imaging studies completed outside of our of office and where we can request the results, if needed.

_____ ☐ None

Medical History Note any diseases or conditions you now have or have had in the past.

Cardiovascular: ☐ Atrial Fibrillation ☐ Heart Attack ☐ Stroke ☐ Deep Vein Thrombosis
☐ High Blood Pressure ☐ Congestive Heart Disease ☐ Transient Ischemic Attack (TIA)

Endocrine: ☐ Diabetes ☐ Gout ☐ Hyperthyroid ☐ Hypothyroid

General: ☐ Hepatitis ☐ Elevated Cholesterol ☐ HIV

Gastrointestinal: ☐ Crohn's Disease ☐ Diverticulitis ☐ Pancreatitis ☐ Inflam. Bowel Disease ☐ Ulcerative Colitis

Genitourinary: ☐ Bladder Cancer ☐ Enlarged Prostate ☐ Kidney Failure ☐ Hematuria (Blood in Urine)
☐ Bladder Leakage ☐ Kidney Cancer ☐ Kidney Stones ☐ Urinary Retention
☐ Elevated PSA ☐ Erectile Dysfunction ☐ Testicular Cancer ☐ Urinary Tract Infections
☐ Interstitial Cystitis ☐ Prostate Cancer ☐ Low Testosterone

Eyes, Ears: ☐ Blindness ☐ Cataracts ☐ Glaucoma ☐ Deafness

Rheumatology: ☐ Rheumatoid Arthritis ☐ Fibromyalgia ☐ Sjogren's Syndrom ☐ Lupus ☐ Immunosuppression

Neurological: ☐ Alzheimer's ☐ Bi-polor Disorder ☐ Depression ☐ Migraines ☐ Multiple Sclerosis
☐ Seizures ☐ Parkinson's

Respiratory: ☐ Asthma ☐ COPD ☐ Emphysema ☐ Tuberculosis ☐ Pulmonary Embolism

Cancer: ☐ Breast ☐ Colon ☐ Leukemia ☐ Lung ☐ Lymphoma
☐ Rectal ☐ Other _____

Cancer Treatment: ☐ Surgery ☐ Chemotherapy ☐ Radiation ☐ Other _____

List any other medical problems not noted above. _____

Surgical History Note any surgeries you have undergone.

Cardiovascular: ☐ Angioplasty ☐ Carotid Artery ☐ Heart Stents ☐ Coronary Artery Bypass
☐ Pacemaker ☐ Heart Valve Replacement

General/GI: ☐ Hernia Repair ☐ Appendectomy ☐ Colon Surgery ☐ Gallbladder Removal

Genitourinary: ☐ Urethral Stricture ☐ Prostate Biopsy ☐ Bladder Suspension ☐ Sound wave treatment of kidney stone (ESWL)
☐ Vasectomy ☐ Removal of Testis ☐ Surgery for Enlarged Prostate (TURP)
☐ Surgery on Kidney ☐ Surgery to Remove Kidney Date of procedure(s) _____

Orthopedic: ☐ Hip Replacement ☐ Knee Replacement ☐ Back Surgery ☐ Knee Scope ☐ Shoulder Surgery

Gynecological: ☐ Uterus Removed ☐ Ovaries Removed ☐ Tubal Ligation
— No. Pregnancies — No. Births — No. Vaginal Delivery — No. C-Sections — Menopause Age

List any other surgeries and their dates. _____

Social History Mark the answer that best describes you.

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated/Divorced ☐ Significant Other

Highest Education: ☐ High School ☐ Vocational/Trade ☐ College ☐ Graduate Degree

Job Status: ☐ Full Time ☐ Part-Time ☐ Student ☐ Retired ☐ Other _____

Alcohol Use: ☐ None ☐ Yes: Drinks Per Day _____ Week _____ Month _____

Smoking/Tobacco Use: ☐ None ☐ Ex-Tobacco User: Date Quit _____ ☐ Tobacco User: Packs/Units Per Day _____

Family History Note the diseases and illnesses your biological family members have had.

Cancer:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Heart Disease:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
High Blood Pressure:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Stroke:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Diabetes:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Kidney Stones:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Enlarged Prostate:		☐ Father	☐ Brother		☐ Grandparent
Prostate Cancer:		☐ Father	☐ Brother		☐ Grandparent

Other family history not noted above: _____

Medical Symptoms Mark any of the symptoms you are currently experiencing.

General:	☐ None	☐ Chills	☐ Fever	☐ Weight Loss	☐ Weight Gain
Eyes:	☐ None	☐ Blurred Vision	☐ Double Vision		
Experiencing Allergies:	☐ None	☐ To Medications	☐ To Food	☐ Seasonal	
Neurological:	☐ None	☐ Dizzy	☐ Headache		
Gastrointestinal:	☐ None	☐ Constipation	☐ Diarrhea	☐ Heartburn	
Muscles and Joints:	☐ None	☐ Arthritis	☐ Cramps	☐ Joint Pain	
Respiratory:	☐ None	☐ Shortness of Breath	☐ Wheezing	☐ Productive Cough	
Hematological	☐ None	☐ Anemia	☐ Bleeding	☐ Swollen Gland	

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URINARY SYMPTOM SCREENER (AUA SYMPTOM SCORE)

Patient Name: _____ Date: _____

Circle the number that best describes your experience.	NOT AT ALL	LESS THAN 1 TIMES IN 5	LESS THAN ½ THE TIME	ABOUT ½ THE TIME	MORE THAN ½ THE TIME	ALMOST ALWAYS
1. INCOMPLETE EMPTYING Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. FREQUENCY Over the past month or so, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. INTERMITTENCY Over the past month or so, how often have you found that you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. URGENCY Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. WEAK STREAM Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. STRAINING Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. NOCTURIA Over the past month or so, how many times did you typically get up to urinate from the time you went to bed until the time you got up in the morning?	None 0	1 Time 1	2 Times 2	3 Times 3	4 Times 4	5 Times 5

Add the score for each question above, and write the total in the space to the right.

SYMPTOM SCORE = 1-7 Mild 8-19 Moderate 20-35 Severe TOTAL _____

QUALITY OF LIFE: How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?

Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
0	**1**	**2**	**3**	**4**	**5**	**6**