UROLOGY SPECIALISTS CLINIC & SURGICAL CENTER **DATE:**_____
DR. LAUREN WOOD THUM - NEW PATIENT FORM

Patient:_____ **Chart:** _____

DOB:_____ **Age:**_____

Pharmacy: _____

Primary: _____

DRUG ALLERGIES:

Medication	Reaction
1.	
2.	
3.	
4.	
5.	

OTHER ALLERGIES:

___IV contrast ___Iodin ___Latex ___other;specify_____

CURRENT PRESCRIPTION MEDICATION(S) - *if you have a current list, you may photocopy and attach*

Name of Medication	Dose and Frequency
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

CURRENT OVER-THE-COUNTER MEDICATION(S), VITAMIN(S), HERBAL SUPPLEMENT(S):

Name	Dose and Frequency
1.	
2.	
3.	
4.	
5.	
6.	

For female patients:

Do you currently use estrogen: YES____ NO____

By what route: (Vaginal, oral, transdermal patch or cream) _____

Past Medical History - Please indicate whether you have been treated for or diagnosed with any of the following conditions.

Genitourinary	**Endocrine**	**Hematological/Lymphatic**
☐ Bladder infection	☐ Hot flashes	☐ Bleeding disorder
☐ Bladder stone	☐ Diabetes	☐ Low blood count
☐ Blood in urine	☐ Hyperthyroidism	☐ Enlarged lymph nodes
☐ Weak stream	☐ Hypothyroidism	☐ Hepatitis
☐ Interstitial cystitis	☐ Other:	☐ HIV/AIDS
☐ Kidney cancer		☐ Other:
☐ Kidney stone		
☐ Sexually transmitted disease		
☐ Transplant donor or recipient	**Cardiac**	**General**
☐ Trauma-Kidney/groin/testicle	☐ Coronary artery disease	☐ Anxiety or Depression
☐ Urinary frequency	☐ Heart attack	☐ High cholesterol
☐ Urinary incontinence	☐ Rhythm disorder	☐ Insomnia
☐ Urinary urgency	☐ High blood pressure	☐ Obesity
☐ Urinary tract infection (UTI)	☐ Peripheral Vascular disease	☐ Glaucoma
☐ Vasectomy	☐ Other:	☐ Radiation treatment (specify location):
☐ Other:		☐ Other:
	Pulmonary	
	☐ Asthma	
	☐ COPD/Emphysema	
Neurology	☐ Lung cancer	
☐ Multiple Sclerosis	☐ Other:	
☐ Stroke		
☐ Parkinson's disease	**Oncologic**	
☐ Multiple system atrophy	☐ Cervical cancer	
☐ Spinal cord injury	☐ Uterine cancer	
☐ Lumbar disk disease	☐ Breast cancer	
☐ Myelodysplasia	☐ Other:	
☐ Other:		

Please list any other medical problems not listed above:

1.
2.
3.
4.

For female patients: Have you had any of the following surgies?

Surgery	Date	Reason
☐ Partial abdominal hysterectomy (cervix still in place)		
☐ Total abdominal hysterectomy		
☐ Vaginal hysterectomy		
☐ Oophorectomy (removal of ovaries)		
☐ Cystocele repair		
☐ Rectocele repair		
☐ Enterocele repair		
☐ Uterine prolapse repair		
☐ Burch procedure		
☐ Sling procedure (mesh used?) Y N		

Past Surgical History - List any additional surgeries not listed above

_____ _____

_____ _____

Have you ever received radiation to your pelvic area? Yes___ No___

Family History - Please list any major illnesses in your siblings, parents, children and grandparents.

Mother: _____ Father: _____

Brother: _____ Sister: _____

Other: _____ Other: _____

OB/GYN History:

Last pap smear?_____ History of abnormal PAP: Yes ____ No ____

Any chance you could be pregnant now? Yes ____ No ____

Number of pregnancies ____

Number of deliveries: cesarean section ____ vaginal delivery ____

Any trauma with deliveries (forceps, tearing of vagina or rectum, etc)? _____

_____

Age at menopause? ____

Social History:

Employment status: _____ Marital status: _____

Smoker? Current: _____ Former: _____ Packs per day: _____ Number of Years: _____

Date quit: _____

Number of alcoholic beverages per week: _____

Sodas per day: _____

Cups of coffee or caffeinated tea per day: _____

Are you currently sexually active? Y_____ N _____ Contraception method? _____

Review of Systems: Please select any **current** symptoms from the list below.

Constitutional	**Genitourinary**
☐ Fever or chills	☐ Urinary frequency
☐ Unexplained weight loss _____ or gain _____	☐ Urinary urgency
HEENT	☐ Waking up at night to urinate
☐ Sore throat	☐ Urinary leakage with urgency; times per day _____
☐ Headaches	☐ Urinary leakage with activity (cough, laugh, sneeze, exercise etc.) times per day _____
Skin	☐ Pads/panty liners per day _____
☐ Rash	☐ Sensation of incomplete bladder emptying
☐ New skin lesions; location _____	☐ Difficulty emptying bladder
Cardiovascular	☐ Difficulty starting stream
☐ Chest pain	☐ Weak urinary stream
☐ Leg swelling	☐ UTI; how often _____
Respiratory	☐ Retention of urine
☐ Shortness of breath	☐ Blood in urine
☐ Cough	☐ Burning or pain with urination
Gastrointestinal	☐ Kidney stones
☐ Nausea and/or vomitting	
☐ Constipation	**Neurological**
☐ Diarrhea	☐ Muscular weakness
☐ Fecal Incontinence (leakage of stool)	☐ Poor coordination
☐ Fecal urgency	☐ Tremor
☐ Straining to defacate	☐ Blurred vision
Gynecological	☐ Double vision
☐ Abnormal vaginal bleeding	☐ Tingling or numbness
☐ Painful menstrual periods	
☐ Unusual vaginal discharge	**Musculoskeletal**
☐ Pain with intercourse	☐ Back pain
☐ Vaginal dryness	☐ Joint pain
☐ Vaginal pain	**Psychiatric**
☐ Vaginal bulge or heaviness	☐ Anxiety
☐ Placing fingers in the vagina to help urinate/defacate	☐ Depression