JOHN MUIR HEALTH

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Urology New Patient (Male)

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

Reason for your visit today? Please be precise.

Physician that referred you for care at John Muir Urology: _____

PAST MEDICAL HISTORY

Do you have or have you had any of the following conditions?	YES	NO	Type / Year Diagnosed
Cancer (kidney, bladder, prostate, testicle, penis)	❑	❑	
Heart (chest pain, heart attack, murmur)	❑	❑	
Have you had an EKG?	❑	❑	When/Where?
High Blood Pressure	❑	❑	
Pacemaker	❑	❑	
Blood or clotting problems	❑	❑	
Stomach/Liver (reflux, bleeding, hepatitis, etc)	❑	❑	
Bowels (change in bowel habits, constipation, diarrhea)	❑	❑	
Glands (Diabetes, thyroid, gout)	❑	❑	
Musculoskeletal (arthritis, disc disease)	❑	❑	
Eyes/Ears/Nose/Throat	❑	❑	
Stroke	❑	❑	
Lungs (Asthma, Emphysema, Pneumonia, shortness of breath, TB)	❑	❑	
Prostate Disease	❑	❑	
Bladder Disease	❑	❑	
Brain/Nervous System (seizure, "blackout spells")	❑	❑	
Mental Illness (Nervous condition/Depression)	❑	❑	
Skin (rash, psoriasis, hives)	❑	❑	
Constitutional (unexplained weight loss, fevers, chills, night sweats)	❑	❑	
Any other illnesses?	❑	❑	
Have you had any accidents/injuries within the last 24 months?	❑	❑	
Have you ever received the Shingles Vaccine?	❑	❑	

PAST SURGICAL HISTORY

Type of Operation	Surgeon	Date(s)

Do you have any artificial joints and/or heart valves? ❑ Yes ❑ No	If yes, give which & date:
Have you ever had a blood transfusion? ❑ Yes ❑ No	If yes, when?

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Names of ***ALL*** Physicians			
Name	**Phone**	**City**	**Specialty**

FAMILY HISTORY

RELATION	AGE(S)	STATE OF HEALTH	IF DECEASED, CAUSE/AGE OF DEATH
Mother			
Father			
Siblings			
Spouse			
Children			
Are you of Ashkenazi Jewish descent?	**YES** ❑	**NO** ❑	

Please list any diseases that run in your family, such as cancer, kidney stones, diabetes, etc.

Disease	Family member

REVIEW OF SYSTEMS

Have you experienced any of these problems during the past month?

	YES	NO		YES	NO
Weight loss	❑	❑	Chest Pain/Palpitations	❑	❑
Fevers	❑	❑	Mood changes or Depression	❑	❑
Chills	❑	❑	Trouble sleeping	❑	❑
Skin rash or itching	❑	❑	Frequent indigestion	❑	❑
Headaches	❑	❑	Nausea or vomiting	❑	❑
Loss of balance or coordination	❑	❑	Diarrhea or constipation	❑	❑
Hearing loss	❑	❑	Jaundice	❑	❑
Vision trouble	❑	❑	Rectal bleeding	❑	❑
Do you wear contacts or glasses?	❑	❑	Foul-smelling urine	❑	❑
Arm or leg weakness	❑	❑	Blood in urine	❑	❑
Sinus drainage	❑	❑			
Difficulty swallowing	❑	❑			
Hoarseness or change in voice	❑	❑			
Sores in mouth or lip	❑	❑			
Cough	❑	❑			
Coughed up or spit up blood	❑	❑			

Patient Name: _____ Date of Birth: _____ Today's Date: _____
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URINARY SYMTOMS

Check appropriate box:	YES	NO
When you urinate, does the stream start immediately?	☐	☐
When the stream starts to flow does it come out:	❑ FAST ❑ MEDIUM ❑ SLOW	
Once the stream is flowing, does it flow continuously?	☐	☐
Do you push or strain to urinate?	☐	☐
When you are finished, do you feel empty?	☐	☐
Do you awaken at night to urinate?	☐	☐
If YES, how many times? _____		
Do you leak urine?	☐	☐
If YES, how many pads do you use per day? _____		
Does it burn or sting when you urinate?	☐	☐
How often do you urinate during the day? *Ex: Every 30 min? Every 2 hrs?* _____		
Do you get the urge to urinate so bad that you do not think you will get to the bathroom in time?	☐	☐
Have you had a sexually transmitted disease?	☐	☐
check one: ❑ Gonorrhea ❑ Chlamydia ❑ Herpes ❑ Genital Warts ❑ Other: _____		
Have you ever had an infection in your urinary tract? (Kidneys, bladder, prostate)	☐	☐

Is there pain in your: *(check all that apply)*
- ❑ Lower abdomen?
- ❑ Groin?
- ❑ Testicles?
- ❑ Behind the scrotum or testicles?

KIDNEY STONES

	YES	NO
1. Do you have pain in the flank or kidney area?	☐	☐
If YES: ❑ Left ❑ Right		
2. Have you ever had a kidney stone?	☐	☐

3. **If NO, skip to next section**
   If YES,
   a) Date(s)? _____
   b) How many? _____
   c) Passed spontaneously? ❑ YES ❑ NO
   d) How was the stone removed? ❑ Surgically ❑ Basket
   e) Lithotripsy (shock therapy)? ❑ YES ❑ NO
4. What was the stone made of? ❑ Calcium ❑ Uric Acid ❑ Other: _____

5. Were you placed on stone prevention therapy?	☐	☐
6. What type? _____		

HEMATURIA

	YES	NO
1. Have you seen blood in your urine?	☐	☐
2. If NO, skip to question 5		
If YES,		
a) Was the blood only at the beginning of the stream?	☐	☐
b) Throughout the stream?	☐	☐
c) At the end of the stream?	☐	☐

3. Was the bloody urine *(check all that apply)*
   - ❑ Tea colored
   - ❑ Rose wine/ cranberry colored
   - ❑ Burgundy wine colored
   - ❑ Clots

4. Was there any pain or burning with the bloody urine?	☐	☐
5. Has a doctor found blood in your urine under a microscope?	☐	☐

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First *Middle Initial* *Last*

ERECTILE DYSFUNCTION	YES	NO
1. Do you have problems with erections?	☐	☐
2. If YES,		
a) Do you awaken in the morning or night with a good erection?	☐	☐
b) Does your sexual partner give you plenty of stimulation (oral/manual) to help you achieve or maintain an erection?	☐	☐
c) Do you have trouble obtaining an erection?	☐	☐
d) Do you have trouble maintaining an erection?	☐	☐
e) Do you have curvature with erections?	☐	☐
f) Do you have painful erections?	☐	☐
g) Is sex an important part of your life?	☐	☐
3. On a scale of 1 to 10, rate the quality of your erections now (10 being when you were 18 years old) _____		
4. When attempting intercourse, how many times out of every 10 tries will you successfully penetrate and achieve orgasm? _____		

SOCIAL HISTORY

(✓)	SUBSTANCE:	APPROXIMATE YEAR STARTED / FREQUENCY:
☐	ALCOHOL	Year: ☐ Never ☐ Rarely ☐ Occasional/Social ☐ Drinks/Day: _____
☐	SMOKING STATUS	❑ Current/Every Day ❑ Current/Some Days ❑ Former Smoker ❑ Never Smoker ❑ Unknown
☐	TOBACCO	Year: Pack(s) A Day: Quit: ☐ NO ☐ YES *If YES*, Date Quit:
☐	STREET DRUGS/OTHER	Year: Type: Do you use needles? ❑ NO ❑ YES
☐	HIV positive or AIDS	☐ YES ☐ NO

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Prostate Health for Men Over 40

Are you bothered by urinary symptoms? Take this test- you may have BPH. BPH (benign prostatic hyperplasia is a non-cancerous enlargement of the prostate that occurs in many men over the age of 40.

Use this form to assess your symptoms, and share your results with your doctor.

To use this symptom scorecard: *Check one number in each line then add all checked numbers to get the total score. The total runs from 0 to 35 points with higher scores indicating more severe symptoms. Scores less than 7 are considered mild and generally do not warrant treatment.*

AUA and BPH SYMPTOM SCORE						
	Not at all	**Less than 1 in 5 time(s)**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost always**
INCOMPLETE EMPTYING Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
FREQUENCY Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
INTERMITTENCY Over the past month, how often have you found you stopped and started again several times when you urinated?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
URGE TO URINATE Over the past month, how often have you found it difficult to postpone urination?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
WEAK STREAM Over the past month, how often have you had a week urinary stream?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
STRAINING Over the past month, how often have you had to push or strain to begin urination?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
URINATING AT NIGHT Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night 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
SYMPTOM SCORE: 1-7 Mild, 8-19 Moderate, 20-35 Severe				**Total: _____**		

BOTHER SCORE DUE TO URINARY SYMPTOMS Rate the bothersomeness of your symptoms by checking the number below that best describes your feelings							
	Delighted	**Pleased**	**Mostly Satisfied**	**Mixed**	**Mostly Dissatisfied**	**Unhappy**	**Terrible**
BOTHERSOME OR URINARY SYMPTOMS How would you feel if you had to live with you urinary condition the way it was now, no better, no worse, for the rest of your life?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6

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CURRENT MEDICATION LIST

DRUG NAME	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

ALLERGIES

☐ None ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Cipro ☐ Macrobid

☐ Other (List All):

MEDICATION	SPECIFIC TYPE OF REACTION

CONSENT TO ACCESS MEDICATION HISTORY

In order to provide you with the best possible care, your prescriptions will be written electronically whenever possible. Electronic prescribing is now a common practice due to healthcare initiatives requiring the use of electronic medical records. With your permission, e-prescribing will provide us access your medication history electronically, enabling us to see critically important information on your current and past prescriptions, better assess potential medication issues, and improve safety and quality of care.

By signing below I give my consent to John Muir Health to access my medication history electronically and to the best of my knowledge, I verify that the above medical information is complete and correct. I understand that it is my responsibility to inform my physician if I ever have a change in my health.

*** **SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

PREFERRED OUTSIDE PHARMACY

Name & Address (Location) of Preferred <u>OUTSIDE</u> Pharmacy: **Is this is a MAIL ORDER PHARMACY? ❑ Yes ❑ No**

Please list a local pharmacy for urgent prescriptions if primary is a mail order.
Name & Address/Phone of LOCAL pharmacy: