UROLOGY CLINIC OF WINCHESTER, P.C.
1712 Amherst Street
Winchester, VA 22601
540-667-1712
Fax 540-665-0045

UROLOGICAL HISTORY AND PHYSICAL

NAME____ AGE______ ACCOUNT # __________________

REFERRED BY ____ TODAY'S DATE _____________________

WHAT IS THE REASON FOR TODAY'S VISIT? (please describe in detail)

____

____

____

LOCATION OF PROBLEM: *(Circle)* ABDOMEN BACK SCROTUM OTHER ______________________

HOW LONG DOES THE PROBLEM LAST?____

____

DOES ANYTHING MAKE THE PROBLEM BETTER OR WORSE? ______________________________________

____

WHEN DID YOU FIRST NOTICE THE PROBLEM? ____

LIST ALL MEDICATIONS YOU ARE TAKING ____

____

____

LIST ALL MEDICATIONS YOU ARE ALLERGIC TO ____

____

LIST PREVIOUS OPERATIONS AND DATES ____

____

____

LIST ANY MEDICAL PROBLEMS YOU MAY HAVE ____

____

____

HAS ANYBODY IN YOUR FAMILY HAD: *(Circle)* KIDNEY STONES HEART DISEASE PROSTATE CANCER

DO YOU SMOKE CIGARETTES? YES NO IF YES, HOW MUCH? ______________________

DO YOU DRINK ALCHOHOLIC BEVERAGES? YES NO IF YES, HOW MUCH? ______________________

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DO YOU KNOW OR HAVE YOU HAD ANY OF THE FOLLOWING? *(Circle Yes or No)*

Constitutional Symptoms: *(within past month)*

Fever/Chills .... Yes No
Weight Loss .... Yes No
Other ____

Eyes:

Blurred Vision .... Yes No
Double Vision .... Yes No
Other ____

Endocrine:

Excessive Thirst .... Yes No
Too hot/cold .... Yes No
Other ____

Gastrointestinal:

Abdominal Pain .... Yes No
Nausea/Vomiting .... Yes No
Other ____

Cardiovascular:

Chest Pain .... Yes No
Heart Attack .... Yes No
Other ____

Respiratory:

Shortness of Breath .... Yes No
Wheezing .... Yes No
Other ____

Allergic/Immunologic:

Hay Fever .... Yes No
Drug Allergies .... Yes No
Other ____

Neurological:

Seizures .... Yes No
Stroke .... Yes No
Other ____

Genitourinary:

Painful Urination .... Yes No
Blood in Urine .... Yes No
Slow Stream .... Yes No
Leaking Urine.................................. Yes No
Urinary Infections .... Yes No
Awakening at Night to Urinate .... Yes No
Difficulty Starting Urination .... Yes No
Other ____

Hematologic/Lymphatic:

Swollen Glands .... Yes No
Blood Clotting Problem .... Yes No
Other ____