TGH Tampa General Hospital | UROLOGY GROUP OF FLORIDA

Patient Name: ______________________ Date of Birth: ______________

Main Reason for your visit: ______________________

MEDICATIONS: LIST ALL MEDICATION YOU ARE PRESENTLY TAKING INCLUDING STRENGTH AND DOSAGE	

Any New Allergies? ☐ NO ☐ YES ______________

Any New Medical Problems? ☐ NO ☐ YES ______________

Any New Surgeries? ☐ NO ☐ YES ______________

Any Change in Family History? ☐ NO ☐ YES ______________

Any Change in Marital Status? ☐ NO ☐ YES ______________

Do you Currently Smoke? ☐ NO ☐ YES ______________

REVIEW OF SYSTEMS (Please Check Positive Complaints.)

Constitutional: ☐ Chills ☐ Fever ☐ Weight loss

Eyes: ☐ Blurred Vision ☐ Eye Pain ☐ Worsening Eyes

Allergies: ☐ Drug ☐ Food ☐ Seasonal

Neurological: ☐ Dizzy ☐ Headache ☐ Seizures

Endocrine: ☐ Thirst ☐ Tired ☐ Hot/Cold

GI: ☐ Heartburn ☐ Diarrhea ☐ Constipation

Kidney Disease: ☐ Renal Failure ☐ Transplant

Cardio: ☐ Chest Pains ☐ Swollen ankles ☐ High Blood Pressure

Skin: ☐ Rash ☐ Lesions ☐ Psoriasis

Musculoskeletal: ☐ Arthritis ☐ Cramps ☐ Gout

ENT: ☐ Sore Throat ☐ Ear Infections ☐ Sinus Problems

Respiratory: ☐Asthma ☐ Shortness of Breath ☐ Cough

Hematologic: ☐Anemia ☐ Easy Bleeding ☐ Swollen Glands

Psychologic: ☐ Anxiety ☐ Depression ☐ Suicidal Thoughts

	Never	Rarely	Sometimes	Half the Time	Often	Always
How often do you lose (leak) urine when you do not want to?	☐	☐	☐	☐	☐	☐
How often do you leak urine during activities like coughing, sneezing, lifting or exercise?	☐	☐	☐	☐	☐	☐
How often do you have difficulty in postponing urination?	☐	☐	☐	☐	☐	☐
How often do you have a strong need to empty your bladder before you start to leak urine?	☐	☐	☐	☐	☐	☐
How often do you lose (leak) urine while you are sleeping?	☐	☐	☐	☐	☐	☐
How many times do you urinate during the daytime?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5+
How many times do you get up at night to urinate?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5+

Have you received treatment for urinary incontinence (leakage) in the past? ☐ NO ☐ YES

Do you wear a form of protection for your leakage? ☐ NO ☐ YES If "YES", how many pads per day? ______________

Do you see blood in your urine? ☐ NO ☐ YES

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

☐ Delighted ☐Pleased ☐Mostly Satisfied ☐Mixed ☐Unhappy ☐Terrible