Orlando Health Urology
Jason Sea, MD

Date: ______________

1. IDENTIFICATION

PATIENT'S AGE:____________

How were you referred to our practice?
Doctor's Name:_________________ Insurance provider:______________
Previous urologist ________________

Race: ☐Caucasian ☐ African American ☐ Hispanic ☐ American Indian/Eskimo ☐ Asian ☐ Pacific Islander ☐ Other

2. CHIEF COMPLAINT

Reason for seeing the urologist today?

☐ Elevated PSA ☐ Kidney Stones ☐ Flank pain ☐ Urinating at night
☐ Incontinence (urine leakage) ☐ Difficulty urinating ☐ Blood in Urine
☐ Recurrent Urinary Tract infections ☐ Erectile dysfunction ☐ other (list below)

Primary problem: ____

3. HISTORY OF PRESENT ILLNESS

Date of first symptoms (problem): _______________
Duration of symptoms (days/weeks/months): ______________
Recently symptom (s) have been: ☐ More Frequent ☐ Less Frequent ☐ More intense
☐ Less intense ☐ Continuous ☐ Periodic
Does anything make it better or worse? ☐ Yes ☐ No
If yes please describe ____

4. PAST MEDICAL HISTORY

General State of Health (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please check anything below that you have or had in the past

☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Depression ☐ Arthritis
☐ Heart trouble ☐ High Blood Pressure ☐ Stroke ☐ Cancer ☐ Diabetes
☐ Kidney infections ☐ Kidney Stones ☐ Bleeding disorder ☐ Alcoholism ☐ STDs
☐ Other ☐ Glaucoma ☐ Bowel obstruction

List all of your previous and current medical conditions (not listed above) _ __________________ ________________
___________________ ______________________ __________________________ _________________________

5. PAST SURGICAL HISTORY

Please list prior surgeries and dates: ___________________ ____________________ ___________________

_____________________ ____________________ _______________________ _______________________

_____________________ ____________________ _______________________ _______________________

6. ALLERGIES

Drug **Reaction to Drug**

Drug allergies/reactions ☐ YES ☐ NO _____________ ____________
_____________ _____________

Other: ______________________________

7. CURRENT MEDICATIONS

Medication	Dosage	Frequency

8. SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Dating
Number of children: ______
Smoking status ☐ Yes currently ☐ Previously but quit ☐ Never before
If yes, how many years? _________ How many packs? __________
Alcohol: ☐ Yes ☐ No If yes, how many years? _________ How much? _____________
Recreational drugs: ☐ Yes ☐ No If yes, how many years? _________ What drug (s)? ___________

Current/prior occupation: _________________
☐ Employed ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Disabled

9. FAMILY HISTORY

Blood Relatives Only	Age of Death	Age if Living	Cause of Death	Current/Past Illness
Father				
Mother				
Brother (s)				
Sister (s)				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				

Patient's Signature: ____ Date: ________________________

Form Reviewed by Physician: ______________________________ Date:____________________

International Prostate Symptom Score (IPSS)

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	**Your score**
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
Frequency Over the past month, how often have you had to urinate again less than two hours after you 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	
Urgency Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
Weak stream Over the past month, how often have you had a weak 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	

	None	1 time	2 times	3 times	4 times	5 times or more	**Your score**
Nocturia Over the past month, many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	

Total IPSS score	

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed – about equally	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Total score: 0-7 Mildly symptomatic; 8-19 moderately symptomatic; 20-35 severely symptomatic.

Review of Systems

Do you have any of the following? ☐ Yes ☐ No

General
Fever ☐ YES ☐ NO
Chills ☐ YES ☐ NO
Recent weight loss ☐ YES ☐ NO
Recent weight gain ☐ YES ☐ NO

HEENT
Headache ☐ YES ☐ NO
Dizziness ☐ YES ☐ NO
Blurred vision ☐ YES ☐ NO
Other________________

Cardiovascular
Palpitations ☐ YES ☐ NO
Swelling ☐ YES ☐ NO
Chest pain ☐ YES ☐ NO
Shortness of breath ☐ YES ☐ NO
Other_________________

Gastrointestinal
Abdominal pain ☐ YES ☐ NO
Nausea ☐ YES ☐ NO
Vomiting ☐ YES ☐ NO
Blood in stools ☐ YES ☐ NO
Diarrhea ☐ YES ☐ NO
Constipation ☐ YES ☐ NO
Ulcers ☐ YES ☐ NO
Other___________________

Hematologic
Anemia ☐ YES ☐ NO
Sickle cell disease ☐ YES ☐ NO
Other_____________________

Integumentary
Skin rash ☐ YES ☐ NO
Easy bruising ☐ YES ☐ NO
Other

Females
Do you take hormone medication? ☐Yes ☐ No
When was your last menstrual period?____________
Are you currently pregnant or think you might be? ☐ Yes ☐ No
Have you ever been pregnant? ☐ Yes ☐ No
If yes, please provide the appropriate numbers for the following:
Vaginal deliveries _____ C-sections____
Miscarriages______ Abortions ____
Vaginal discharge ☐ Yes ☐ No
Vaginal dryness ☐ Yes ☐ No
Excessive vaginal bleeding ☐ Yes ☐ No
Sexual problems ☐ Yes ☐ No
(Loss of desire, pain)
Infertility (can't have children) ☐ Yes ☐ No

Neurological
Tremors ☐ YES ☐ NO
Seizures ☐ YES ☐ NO
Numbness/tingling ☐ YES ☐ NO
Muscle spasms ☐ YES ☐ NO
Other____________________

Musculoskeletal
Joint stiffness ☐ YES ☐ NO
Joint pain ☐ YES ☐ NO
Back pain ☐ YES ☐ NO
Muscle weakness ☐ YES ☐ NO
Other____________________

Respiratory
Difficult breathing ☐ YES ☐ NO
Shortness of breath ☐ YES ☐ NO
Frequent cough ☐ YES ☐ NO
Other_____________________

Psychiatric
Depression ☐ YES ☐ NO
Anxiety ☐ YES ☐ NO
Eating disorder ☐ YES ☐ NO
Other: ____________________

Genitourinary
Frequent daytime urination? ☐ Yes ☐ No
If yes, how often_________
Frequent nighttime urination? ☐ Yes ☐ No
If yes, how often_________
Leakage of urine? ☐ Yes ☐ No
with ☐ cough ☐ laugh ☐ sneeze
Unable to get to restroom in time? ☐ Yes ☐ No
Pain with urination? ☐ Yes ☐ No
Decrease in urinary flow? ☐ Yes ☐ No
Frequent bladder infection? ☐ Yes ☐ No
If yes, how often?_________
Do you wear pads for urinary leakage? ☐ Yes ☐ No
If yes, how many per day? __________

Males
☐ Potency ☐ Erectile dysfunction
☐ Prostate disease ☐ Testicle pain
Sexual problems
☐ Yes ☐ No
(Loss of desire, pain)
Infertility (can't have children)
☐ Yes ☐ No