

New Patient/Annual MALE GENITOURINARY EXAM

Patient Name _____ Age _____ Date of Visit _____

What is the main reason for your visit today? Describe your problem in detail _____

PLEASE ANSWER SET OF THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE:

• WHERE is your problem?

Abdomen / Back / Gen/ab / Other _____

Describe: _____



• Do you have any PAIN?

YES NO (If NO skip the next question)

• What KIND of pain do you have? Sharp / Dull / Throbbing / Achy /

Pressure / Clamping / Cramping / Itching _____

Describe: _____

• On a scale of 1-10, (10 is the most severe) circle the number that

best describes the SEVERITY of your problem or your pain.

(no problem) 1 2 3 4 5 6 7 8 9 10 (most severe)

• When did you FIRST NOTICE the problem? (When did it start?)

How many (circle one) days / weeks / months ago: _____

• HOW LONG does each episode last?

Seconds / Minutes / Hours / Days / Always there

Describe: _____

• WHEN does this problem happen?

Daytime / Nighttime / When you are active / Unpredictable

Describe: _____

• HOW OFTEN are you having the problem or the pain?

Describe: _____

• What HELPS or what makes the problem WORSE?

Describe: _____

• Are any OTHER SYMPTOMS occurring at the same time?

Describe: _____

• List all of your current health conditions, and list all

hospitalizations and surgeries you have had: _____

• List all medications you are taking regularly: _____

• List all medication allergies: _____

• Do you smoke? No Yes How Much? _____

• Do you use drugs or alcohol? No Yes How Much? _____

• What is/are your occupation? (What did you retire from?) _____

• What is your current marital status?

Single / Married / Separated / Divorced / Widowed

• List all serious illnesses in your family, including parents, grand-
parents and siblings. Diabetes, any kind of cancer, high blood
pressure, heart disease, kidney disease or stones, thyroid disease, etc.)

Mother: _____

Maternal GH: _____

Paternal GH: _____

Father: _____

Paternal GH: _____

Paternal GH: _____

Bro./Sis.: _____

• Do you have any of the following problems TODAY? Please mark YES (Y) or NO (N) for EACH item below.

<input type="checkbox"/> N Kidney disease	<input type="checkbox"/> Y N Fever	<input type="checkbox"/> Y N Wheezing	<input type="checkbox"/> Y N Back pain	<input type="checkbox"/> Y N Easy bruising
<input type="checkbox"/> Y N Blurry vision	<input type="checkbox"/> Y N Chills	<input type="checkbox"/> Y N Frequent cough	<input type="checkbox"/> Y N Headaches	<input type="checkbox"/> Y N Seasonal allergies
<input type="checkbox"/> Y N Painful urination	<input type="checkbox"/> Y N Change in Weight	<input type="checkbox"/> Y N Short of breath	<input type="checkbox"/> Y N Thromb	<input type="checkbox"/> Y N Other health problems
<input type="checkbox"/> Y N Urinary hesitancy	<input type="checkbox"/> Y N Change in appetite	<input type="checkbox"/> Y N Abdominal pain	<input type="checkbox"/> Y N Numbness or tingling	
<input type="checkbox"/> Y N Urinary retention	<input type="checkbox"/> Y N Blurred/double vision	<input type="checkbox"/> Y N Nausea	<input type="checkbox"/> Y N Dizzy Spells	
<input type="checkbox"/> Y N Urinary frequency	<input type="checkbox"/> Y N Eye pain	<input type="checkbox"/> Y N Vomiting	<input type="checkbox"/> Y N Anxiety	
<input type="checkbox"/> Y N Urinary urgency	<input type="checkbox"/> Y N Ear pain	<input type="checkbox"/> Y N Indigestion	<input type="checkbox"/> Y N Depression	
<input type="checkbox"/> Y N Urinary incontinence	<input type="checkbox"/> Y N Hearing loss	<input type="checkbox"/> Y N Heartburn	<input type="checkbox"/> Y N Irritability	
<input type="checkbox"/> Y N Incontinence	<input type="checkbox"/> Y N Sore throat	<input type="checkbox"/> Y N Blk stools	<input type="checkbox"/> Y N Excessive thirst	
<input type="checkbox"/> Y N Drinking/Wet Bow	<input type="checkbox"/> Y N Chest pain	<input type="checkbox"/> Y N Joint pain	<input type="checkbox"/> Y N Intolerant to heat/cold	
<input type="checkbox"/> Y N Nighttime urination slow many?	<input type="checkbox"/> Y N Varicose veins	<input type="checkbox"/> Y N Neck pain	<input type="checkbox"/> Y N Tired or fatigued	
			<input type="checkbox"/> Y N Swollen Glands	

Physician's provider use only (not for patient)

Patient was offered CaP screening Yes No

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