

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 / Itchy
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 (whole 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(s) (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, grandparents and siblings. (Diabetes, any kind of cancer, high blood pressure, heart disease, kidney disease or stones, thyroid disease, etc.)

Mothers: _____
Maternal GH: _____
Maternal GH: _____
Fathers: _____
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.

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

Physician's provider use only (not for insurance)

Patient was offered CaP screening Yes No

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