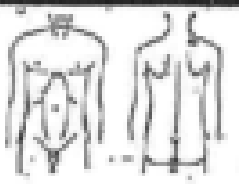
New Patient/Annual MALE GENITOURINARY EXAM

Patient Name _____ Age: _____ Date of Visit: _____

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

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

- WHERE is your problem? Abdomen / Back / Genitals / 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 / Cramping / Crushing / Vague. 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 / month(s) 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 take regularly: _____
- List all medication allergies: _____
- Do you smoke? No Yes How Much? _____
- Do you use drugs or alcohol? No Yes How Much? _____
- What is/was 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, grandparents and siblings. (Diabetes, any kind of cancer, high blood pressure, heart disease, kidney disease or stones, thyroid disease, etc.)

Mother: _____
Maternal GM: _____
Maternal GF: _____
Father: _____
Paternal GM: _____
Paternal GF: _____
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	Bloody urine	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	Tremors	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	Insomnia		
Y N	Impotence	Y N	Sinus problems	Y N	Skin problems	Y N	Excessive thirst		
Y N	Dribbling/slow flow	Y N	Sore throat	Y N	Skin cancer	Y N	Intolerant to heat/cold		
Y N	Nighttime urinations	Y N	Chest pain	Y N	Joint pain	Y N	Tired or fatigued		
	How many? _____	Y N	Varicose veins	Y N	Neck pain	Y N	Swollen Glands		

Physician / provider use only (Initial assessment)

Patient was offered CaP screening ☐ Yes ☐ No

Time in: _____