Valley Urologic Associates

NEW PATIENT HISTORY AND PHYSICAL FORM

Date: _____
Name_____
Date of Birth: _____
Age: _____
Primary care Doctor: _____

Past Medical and Surgical History (Please fill out completely)

Do you have any drug **allergies**: ☐ No known Drug Allergies

☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Cipro/Levaquin ☐ Erythromycin ☐ IV Iodine ☐ Macrobid ☐ Gentamycin

Other Allergies: _____

Do you have any **medical problems** in the past or currently taking medications for: ☐ None

☐ Diabetes	☐ High Blood Pressure	☐ Coronary Heart Disease	☐ Atrial Fibrillation	☐ Asthma
☐ COPD	☐ Kidney Stones	☐ Hypothyroidism	☐ Hypercholesterolemia	☐ Stroke
☐ Gastric Reflux	☐ Gout	☐ Arthritis	☐ Morbid Obesity	☐ Seizures
☐ Seasonal Allergies	☐ Depression	☐ Cancer (Type _____)		

PLEASE LIST ANY OTHER MEDICAL PROBLEMS (NOT LISTED ABOVE) THAT YOU HAVE BEEN TREATED IN THE PAST:

_____
_____
_____

Please list all your past **surgeries** : ☐ None

☐ Appendectomy	☐ Tonsillectomy	☐ Hysterectomy (uterus)	☐ Cholecystectomy (gall bladder)
☐ Spine Surgery	☐ Colonoscopy	☐ Hernia Location _____	☐ Hip Replacement
☐ Knee ☐ R ☐ L	☐ Shoulder ☐ R ☐ L	☐ Coronary Stents	☐ Coronary Bypass Graft ___ vessels
☐ C- Section	☐ Tubal Ligation	☐ Gastric Bypass	☐ Peripheral Vascular Bypass

PLEASE LIST ANY OTHER SURGICAL PROCEDURES (NOT LISTED ABOVE) THAT YOU HAVE BEEN TREATED IN THE PAST:

_____
_____
_____

Please list all of your **medications/Supplements**: (include name, dosage, and how many times a day): ☐ None

_____
_____
_____
_____
_____
_____

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Patient Name _____ DOB _____ AGE _____ DATE _____

PHYSICIAN SIGNATURE _____

NEW PATIENT HISTORY AND PHYSICAL FORM

Please detail your **social** history:

Do you smoke: ☐ Yes ☐ No How many packs a day? _____ For How many years _____

Have you quit: ☐ Yes ☐ No What year _____

Do you drink alcohol ☐ Yes ☐ No How many drinks per week _____

Do you use any illicit drugs (please list) : _____

Please detail your **family** history: (any disease that your parents, grandparents, or siblings have had)

Prostate cancer ☐ Kidney Cancer ☐ Bladder Cancer ☐ Kidney Stones ☐

PLEASE LIST ANY OTHER FAMILY PROBLEMS (NOT LISTED ABOVE):

_____

_____

Are you Married ☐ Single ☐ Divorced ☐ Widowed ☐

How many pregnancies (if applicable): _____ How many children do you have: _____

What is your occupation: _____

Review of systems (please check any ***new*** symptoms that you have recently had)

Genitourinary ☐Urinary frequency ☐Urinary urgency ☐Blood in the urine ☐Flank pain ☐Sense of not empyting bladder ☐Burning/ painful urination ☐Incontinence of urine **Constitutional** ☐Fever ☐Chills ☐Headaches **Integumetary** ☐Skin rash ☐Boils ☐Persistent itch **Gastrointestinal** ☐Hepatitis ☐Ulcer/reflux ☐Constipation	**Musculoskeletal** ☐Back pain/surgery ☐Muscle disorder ☐Joint disorder **Sight/Sound** ☐Blurred vision ☐Glaucoma ☐Loss of hearing/ringing **Pulmonary** ☐Wheezing ☐Frequent Cough ☐Shortness of breath **Endocrine** ☐Diabetes ☐Thyroid disease ☐Parathyroid disease **Ear/Nose/Throat** ☐Ear infection ☐Sore Throat ☐Difficulty Swallowing	**Circulatory** ☐Chest pain ☐High blood pressure ☐Varicose vein **Neurological** ☐Dizziness ☐Migraine ☐Multiple Sclerosis **Hematologic/Lymphatic** ☐Lymph node swelling ☐Bleeding disorder ☐Immune disorder (HIV)

What is your Height _____ What is your Weight: _____

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FOR PHYSICIAN USE ONLY

Chief Complaint:_____

HPI: _____

_____

_____

_____

_____

_____

Gross Hematuria Y ☐ N ☐ Flank pain Y ☐ N ☐ Fevers Y ☐ N ☐ Nausea/Vomiting Y ☐ N ☐ Incontinence Y ☐ N ☐

PHYSICAL EXAM

VITALS: HR _____ TEMP _____ RR _____ BP _____

GENERAL: NAD ☐ Other _____

PSYCHIATRIC: A X O ☐ Normothymic ☐ Other _____

HEAD: Atraumatic ☐ Normocephalic ☐ Other _____

EYES: PERRLA ☐ Normal Conjunctiva ☐ Other _____

NECK: Bruits N☐ JVD N ☐ Other

LYMPHATIC: Lyphadenopathy at Supraclavicular N☐ Inguinal N ☐ Neck N☐

CHEST:: Symmetric ☐ CTA bilaterally ☐ Other _____

CORONARY: Regular Rate ☐ Regular Rhythm ☐ Other _____

EXTREMITIES: Cyanosis N☐ Edema N☐ Other _____

ABDOMEN: Soft ☐ Non- Tender ☐ Other _____

NEUROLOGICAL: Grossly Non Focal ☐ Normal Gait ☐ Other _____

GENITOURINARY MALE:

Penis: Phimosis ☐ Circumcised Y ☐ N☐ Testes: Descended R ☐ L ☐ Masses_____

Epididymis: Masses N ☐ _____ Urethral Meatus Patent ☐ Other _____

Prostate: Size _____ Smooth ☐ Nodules/Induration ☐_____

GENITOURINARY FEMALE:

Deferred to cystoscopy for pelvic exam ☐ External Genitalia Female ☐ _____

Uterus: Normal ☐ Absent ☐ Prolapsed ☐ Urethal Meatus Patent ☐ Mass ☐ _____

Vaginal: Cystocele ☐ Enterocele ☐ Rectocele ☐ Desc: _____

Cervix: Absent ☐ Normal ☐ Adnexa: Tender ☐ Mass ☐

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FOR PHYSICIAN USE ONLY – PREVIOUS LABS/ IMAGING

LABS:

IMAGING:

FOR PHYSICIAN USE ONLY – DIAGNOSIS

Primary Diagnosis : _____

Quarternary Diagnosis: _____

Secondary Diagnosis: _____

Pentanary Diagnosis: _____

Tertiary Diagnosis: _____

Sextanary Diagnosis: _____

FOR PHYSICIAN USE ONLY – ORDERS

- ☐ PSA
- ☐ PSA Free/Total
- ☐ BMP
- ☐ CBC
- ☐ PT/ INR
- ☐ Urinalysis and Culture
- ☐ Urine Cytology
- ☐ Liver Function Tests
- ☐ Testis Cancer Markers
- ☐ Adrenal Incident Tumor panel
- ☐ STD Urine GC/Chlamydia PCR
- ☐ CT Stone Protocol
- ☐ CT Without / With contrast
- ☐ MRI Abdomen without/with
- ☐ MRI Pelvis without/with
- ☐ KUB
- ☐ Renal Ultrasound
- ☐ Scrotal Ultrasound
- ☐ VCUG
- ☐ Nuclear MAG 3 Renal Scan w/ Lasix
- ☐ Whole Body Bone Scan
- ☐ Intravenous Pyelogram
- ☐ Cystoscopy
- ☐ TRUS biopsy
- ☐ TRUS Measurements
- ☐ Urodynamics Studies
- ☐ Uroflowtometry/ PVR
- ☐ Ultrasound PVR
- ☐ Testosterone Replacement Panel
- ☐ Litholink Evaluation Panel
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

FOR PHYSICIAN USE ONLY – NOTES

_____

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