UROLOGY
MICHAEL C SOLOMON
M.D., P.A., F.A.C.S.

Patient's Name: _____ Date: _____
(last) (first)

Age: ____ DOB:_____ Referring Dr:_____Primary Dr:_____

Marital Status:_____

---

What is the main reason for your visit today? Write in your own words on the lines provided:

_____

_____

**Are you allergic to:**

Latex _____Dye _____ IV Contrast ☐ Shellfish____ Shrimp☐ Iodine _____ Betadine_____
Tape / Adhesives ____ Anesthetics _____ Penicillin _____ Sulfa _____ Cipro / Levaquin _____

N.K.D.A _____ Other Medication allergies:

_____

**MEDICATIONS:**

**What is the name and number of your preferred pharmacy**: _____

**Are you currently taking the following blood thinners?**
Aspirin 81 mg or 325 mg / Motrin or Aleve / Ibuprofen/ Celebrex/ Mobic / Fish oil/ Coumadin/ Warfarin/ Plavix / Pradaxa/ Xarelto/ Eliquis / Heparin / Lovenox / Vitamin E

**Please list all the medications you take with the dosage and frequency of medication including over the counter:**

| Medication | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**General Surgeries/ Procedures**

| Year | Procedure/ Surgery |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Patient Name: _____**

**UROLOGIC HEALTH HISTORY**

Do you have a history of any of the following?

***Prostate Cancer*:** Yes / No ***Bladder Cancer*:** Yes / No ***Kidney Cancer***: Yes / No ***Testicular Cancer***: Yes / No
***Kidney Disease/ Stones*:** Yes / No

**Treatments**: Prostatectomy _____ Radiation _____Bladder Tumor Removal _____

Bladder Removed _____ Nephrectomy _____ Lithotripsy _____ BCG _____ Orchiectomy _____

Previously seen Urologist? _____

When were you diagnosed? _____ Who diagnosed you? _____

Have you had any recent test to evaluate this problem? KUB / CT scan / MRI / IVP / Ultrasound / Nuclear bone scan nuclear renal scan / PSA / Cystoscopy

==========

**PAST AND PRESENT MEDICAL CONDITIONS:**
**Circle those that apply**

Irregular heartbeat / Carotid artery disease/ Congestive heart failure / High blood pressure/ High cholesterol / Heart attack / Peripheral vascular disease/ Heart valvular disease / renal artery stenosis / Heart disease/ AFIB Asthma / COPD / Cystic fibrosis / pulmonary embolism / Sleep apnea/ Tuberculosis / Cirrhosis / Crohn's disease Heartburn /GERD / Hepatitis B / Hepatitis C / Irritable bowel syndrome / Peptic ulcer disease / Ulcerative colitis / Diverticulitis / Kidney failure / Endometriosis / Polycystic kidney disease / Kidney stones/ Kidney Infections UTI/ Kidney obstruction / Enlarged prostate / BPH / Prostate infection / STD's / Fibromyalgia/ Gout Osteoporosis / Rheumatoid arthritis / Lupus / Cushing's disease / Diabetes 1-2 / Hyperthyroidism / Hypothyroidism / Alzheimer's / Bipolar / Stroke / Dementia / Multiple sclerosis / Parkinson disease / Seizures / TIA / Blood clots / HIV/AIDS / Glaucoma / Drug dependency / Depression / Breast cancer / Cervical cancer / Colon cancer / Lung cancer / Skin cancer / Uterine cancer / Other:_____

Do you have Cardiac Stents: Yes / No

| Physician use only |
| --- |
| |

**Patient Name: _____**

## Females Only:

Have you had a hysterectomy? Yes / No
Have you had any prior bladder surgeries/when? _____
Have you had a sling/when? _____
Do you have blood in the urine? Yes / No
Do you leak urine? Yes / No
Is your leakage associated with the urge to urinate? Yes / No
Is your leakage associated with coughing, laughing, jumping, sneezing, or exercising Yes / No
Do you wear protective pads? Yes / No
How many Pads/day? _____ Liners/day? _____Diapers/day? _____
Other: _____ Are they usually: Dry / Moist / Wet / Soaked

## Men only:

Do you have a problem with libido/desire? Yes / No
Do you have a problem achieving or maintaining an erection? Yes / No
Have you tried any medications for erectile dysfunction? Yes / No
Please indicate which medication(s) below: Viagra /Cialis / Levitra /Staxyn /MUSE / BiMix / TriMix / VED
Other:_____
Are you currently or have you been treated for Low Testosterone? Yes / No
What medications have you tried: Androgel / Testim / Testosterone injections/ Testosterone pellets
Who has been treating you?_____

**Men & Women:**

Do you experience any of the following?
Urinary urgency / Urinary frequency / Burning with urination / Weak stream / Straining to urinate/ Trouble starting / Dribbling /
How many times do you wake up to urinate at night? 0 1 2 3 4 5 6 7 8 9 10
Do you feel like your emptying your bladder completely? Yes / No
Are there any other urologic issues you would like to discuss with Dr. Solomon today? Yes / No
(Please explain)
_____

**Family History** (please indicate which family member)

☐ Heart Disease _____
☐ Lung Disease _____
☐ High Blood Pressure _____
☐ Strokes_____
☐ Kidney Disease/ Stones_____
☐ Bladder Cancer _____
☐ Diabetes _____
☐ Arthritis _____
☐ Cancer _____
☐ Prostate Disease/ Cancer_____
☐ High Cholesterol_____
Other: _____

**SOCIAL HISTORY:**

Tobacco/ Alcohol History
Do you currently smoke? / Yes / No How much? _____
Did you smoke in the past? Yes / No How long? _____ When did you quit? _____
Do you drink alcohol? Yes / No How many drinks per day? _____
Do you use recreational drugs? Yes / No Substances: _____
How much caffeine do you drink daily? _____
Have you ever had a blood transfusion: Yes / No

**Patient Name _____**

## Review of Systems

Do you currently have any of these problems related to the areas outlined below: ***Please circle those that apply***

CONSTITUTIONAL SYMPTOMS

Fever Chills Headaches Weight Loss Other_____

__*negative review*

EYES/EARS/NOSE THROAT

Hearing Loss Ringing in Ears Eye Pain Difficulty Swallowing

Blurred Vision Double Vision Nasal Stuffiness Other_____

__*negative review*

RESPIRATORY

Frequent Cough Wheezing Shortness of Breath Other_____

__*negative review*

CARDIOVASCULAR

Chest Pain Varicose Veins High Blood Pressure

Swollen Ankles Irregular Heart Beat Other_____

__*negative review*

GASTROINTESTINAL

Stomach Pain Nausea Vomiting Constipation Diarrhea Other_____

__*negative review*

NEUROLOGICAL

Numbness Tremor Dizziness Numbness/Tingling Other_____

__*negative review*

MUSCULOSKELETAL

Joint Pain Back Pain Neck Pain Sore Muscles Other_____

__*negative review*

ENDOCRINE

Excessive Thirst Temperature Intolerance Tired/ Sluggish Other_____

__*negative review*

SKIN

Rashes Itching History of Skin Cancer Other_____

__*negative review*

HEMATOLOGIC / LYMPHATIC

Swollen Glands Abnormal Bleeding Transfusion History

__*negative review*

Thank you for taking the time to complete your urological health questionnaire.
Welcome to our practice

Patient Name: _____

## ****MEN ONLY ****

## AMERICAN UROLOGICAL ASSOCIATION (AUA) SYMPTOMS FOR BPH

| Questions to be answered regarding your BPH condition | 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 | |
|---|---|---|---|---|---|---|---|
| | *Select one button for each category* | | | | | | |
| Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating? | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 | ◯ 4 | ◯ 5 | ☐ |
| Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating? | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 | ◯ 4 | ◯ 5 | ☐ |
| Over the past month, how often have you stopped and started again several times when you urinated? | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 | ◯ 4 | ◯ 5 | ☐ |
| Over the past month, how often have you found it difficult to postpone urination? | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 | ◯ 4 | ◯ 5 | ☐ |
| Over the past month, how often have you had a weak urinary stream? | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 | ◯ 4 | ◯ 5 | ☐ |
| Over the past month, how often have you had to push or strain to begin urination? | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 | ◯ 4 | ◯ 5 | ☐ |
| Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning? | ◯ 0 times | ◯ 1 time | ◯ 2 times | ◯ 3 times | ◯ 4 times | ◯ 5 times | ☐ |
| | | | | | | | **Score** ☐ |