**MARQUETTE GENERAL UROLOGY** Date: _____

**PATIENT INTAKE FORM**

Patient Name: _____ Age: _____ Birthdate: _____

Referring Physician: _____ Family Physician: _____

**CHIEF COMPLAINT:**

_____

**Brief Reason for your visit today**

_____

_____

How long has this been going on? _____ days/months/years. Anything make it better? _____
Anything make it worse? _____

**Past Medical History**

**MEDICAL ILLNESS:** ☐ None ☐ Stroke ☐ Neurological problems ☐ Hepatitis/Jaundice ☐ Bleeding Tendency ☐ Kidney Stones ☐ Prostate Cancer ☐ Hypertension ☐ Diabetes ☐ Incontinence ☐ Other _____

**SURGERIES:** ☐ None ☐ Gallbladder ☐ Appendectomy ☐ Hysterectomy ☐ Prostate Surgery ☐ Colorectal ☐ Kidney ☐ Heart ☐ Tonsillectomy ☐ Hernia ☐ Incontinence Procedures ☐ Other _____

**MEDICATIONS:** ☐ **None** or.....Please list medications below – include over-the-counter medications

| Name of Medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

☐ Separate sheet of paper attached for additional Medications

**ALLERGIES:** ☐ **None** ☐ Latex ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Demerol ☐ Morphine ☐ Darvocet ☐ Tetanus ☐ Other: _____

**SOCIAL HISTORY**

Marital status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single ☐ Separated
Tobacco Use: ☐ No ☐ Yes How much? _____ Quit Date: _____
Alcohol Use: ☐ No ☐ Yes How much? _____ Drug Use: ☐ No ☐ Yes Type _____

**FAMILY HISTORY**

Mother: ☐ Alive Age _____ ☐ Deceased of/what _____
Father: ☐ Alive Age _____ ☐ Deceased of/what _____
Is there any Family History of: ☐ Diabetes Who? _____ ☐ Cancer Who? _____
☐ Heart Disease Who? _____ ☐ Other _____

Did you bring any medical records with you today? ☐ No ☐ Yes from? _____



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# REVIEW OF SYSTEMS

Please check any current problems/symptoms you have experienced in the last 6 months.

**CONSTITUTIONAL:**
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Appetite change
- ☐ Unexpected weight change
- ☐ None

**NEUROLOGIC:**
- ☐ Dizziness
- ☐ Headaches
- ☐ Speech Difficulty
- ☐ Fainting
- ☐ Tremors
- ☐ None

**CARDIOVASCULAR:**
- ☐ Chest Pain or Pressure
- ☐ Leg Swelling
- ☐ Palpitations (racing heart beats)
- ☐ None

**RESPIRATORY:**
- ☐ Shortness of Breath
- ☐ Waking up Short of Breath
- ☐ Choking
- ☐ Stop Breathing at Night
- ☐ Cough
- ☐ Chest Tightness
- ☐ Wheezing
- ☐ Asthma
- ☐ Shortness of Breath with lying down
- ☐ None

**EARS, NOSE, MOUTH & THROAT:**
- ☐ Hearing Loss
- ☐ Ringing in the Ears
- ☐ Postnasal Drip
- ☐ Dental Problems
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Sore Throat
- ☐ None

**GASTROINTESTINAL:**
- ☐ Blood in Stool
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Rectal Pain
- ☐ Vomiting
- ☐ Trouble Swallowing
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ None

**GENITOURINARY:**
- ☐ Urine Incontinence
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Urinary Frequency
- ☐ Dialysis
- ☐ Kidney Disorder
- ☐ History of Urinary Tract Infections
- ☐ Sleep Interrupted to Urinate
- ☐ Blood in Urine
- ☐ Kidney Transplant/Removal patient
- ☐ Erection Trouble more than 50% of the time
- ☐ None ☐ Other _____

**MUSCULOSKELETAL:**
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Gait Problem
- ☐ Joint Swelling
- ☐ Muscle Weakness
- ☐ None

**SKIN:**
- ☐ Skin Color Changes
- ☐ Bruising
- ☐ Rash
- ☐ Lesions
- ☐ None

**EYES:**
- ☐ Eye Redness/pain
- ☐ Visual Disturbance
- ☐ Glaucoma
- ☐ None

**BLOOD/ LYMPH PROBLEMS:**
- ☐ Swollen Lymph Nodes
- ☐ Bleeds/Bruises easily
- ☐ Clotting Problems
- ☐ None

**BREASTS:**
- ☐ Nipple Discharge
- ☐ Breast Pain

**BEHAVIORAL/PSYCHOLOGICAL:**
- ☐ Anxiety
- ☐ Depression
- ☐ Behavior Problems
- ☐ Sleep Disturbance
- ☐ Suicidal Thoughts
- ☐ Self-Injury
- ☐ None

**ENDOCRINE:**
- ☐ Heat or Cold Intolerance
- ☐ Excessive Sweating
- ☐ Thyroid Problems
- ☐ None

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date