

Northeast Georgia Urological Associates		Clinical Information		
Patient name:		DOB:	Height:	Weight:
Sex:				
Pharmacy Name:		Pharmacy location:		
Pharmacy Name:		Pharmacy location:		
What is the main urology problem we are treating:				
Please circle other urology problems:				
Bladder cancer	Bladder infection	Bladder leaking	Decreased stream	
Burning with voiding	Void at night	Blood in urine		
Kidney stones	Kidney cancer	Cyst on my kidney	Kidney failure	
Urinary tract infections	Abnormal test/xray	Had chemotherapy	Had radiation	

Female	Abnormal female exam	Cancer of uterus/cervix ovaries	Change in sexual desire
	Vaginal discharge	Feels like something is coming out	
	Pain with sexual activity	Vaginal dryness	

Other			
Male	Abnormal prostate exam	Cancer of uterus/cervix ovaries	Change in sexual desire
	Prostate infection	Erectile dysfunction	Change in sexual desire
	Testicle problems		
Other			

Please circle any allergies:	None	Xray dye	Latex	Tape
	betadine	Cipro	Penicillin	Iortab
Other				

Please circle any of the medications your are currently taking:				
Estrace cream	macrodantin	Cipro	Septra/bactrim	Vesicare
Detrol	Enablex	Oxybulynin	Myrbelrig	Rapaflo
Flomax	Hytrin	Proscar	Avodart	Jalyn
Cialis	Viagra	Levitra	Staxyn	MUSE
Testosterone injections	Testosterone cream	Uribell	Pyridium	Phenergan
Zofran	Lortab	Percocet	Ultram	Toradol
Aspirin	Coumadin	Plavix		
Other medications				

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Please circle any surgeries you have had			Prostate	Testicle	Kidney stone	
Bladder	Sling		Bone/joint	Back	Eye	
Heart	Cancer		other			
Please circle any of these medical problems you have been diagnosed with						
Cataracts		Glaucoma	COPD/emphysema		Asthma	Thyroid
Sleep apnea		Heart failure		Heart attack		High blood pressure
Irregular heart beat		Hiatal hernia		Skin cancer		Stroke
Parkinson's disease		Seizures/epilepsy		Blood clots		Anemia
Alzheimer's disease		Dementia		Diabetes		Cancer
Please circle any of these medical problems you have been diagnosed						
Constitutional:	Chills		Fever	Weight loss		Anesthesia problems
Eyes	Glasses		Contacts			
EENT:	Hearing loss					
Cardiovascular:	Chest pain					
Respiratory:	Shortness of breath		Oxygen			
Gastrointestinal:	Abdominal pain		Constipation	Nausea/vomiting		Heartburn
Musculoskeletal	Arthritis		Back pain	Muscle weakness pain		Wheelchair
Skin:	Bruising		Drain sores	Rash		MRSA
Neurological:	Dizziness		Numbness			
Hematology:	Long bleeding time					
Breast	Mass/lump					
Endocrine	Poor healing time		Excessive thirst			
Psych	anxiety	depression	Suicidal	Memory loss	Other mental health problems	
Please circle any of these problems in you family history				Bladder cancer		Breast cancer
Colon cancer	Diabetes		Heart disease		Kidney cancer	Kidney stones
Lung cancer	Polycystic kidneys		Prostate cancer			
Smoking history	Current every day		Some days smoker		Former smoker	Never smoked
Do you drink alcohol:			Yes		Have quit	Never
Recreational drugs:			Yes		Have quit	Never
How many caffeinated drinks do you have each day						