

Middle Tennessee Urology Specialists

MRN # _____

Doctors: Cleveland, Dray, Jackson, Shepard, Showalter

Urochart Intake Form

Patient Name: _____

Date: _____

Who referred you to this office? _____ Medical Doctor/PCP: _____

Why are you seeing the physician today: _____

When did your problem start: _____ Pharmacy (Name & Number): _____

My Main Problems are:

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Bladder Pain | <input type="checkbox"/> Dropped Bladder |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Leak Urine | <input type="checkbox"/> Overactive Bladder | <input type="checkbox"/> Straining |
| <input type="checkbox"/> Frequency | <input type="checkbox"/> Urgency | <input type="checkbox"/> Leakage | <input type="checkbox"/> Not Emptying Bladder | |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Bladder Pain | <input type="checkbox"/> Pain in Side R / L | <input type="checkbox"/> Urinating at Night # _____ | |
| <input type="checkbox"/> Other _____ | | | | |

Allergies

- None Penicillin Sulfa Cipro Iodine/contrast
 Other _____

Medications Please list all medications: _____

Surgical History

- | | | | | |
|---------------------------------------|--|---|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Back/Hip/Knee | <input type="checkbox"/> Bladder Tack | <input type="checkbox"/> C – Section # _____ | |
| <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Kidney Stone Surgery |
| <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Sling (TVT) | <input type="checkbox"/> Vaginal Deliveries # _____ | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> No Changes | | | | |

Medical History

- | | | | | |
|--------------------------------------|------------------------------------|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Murmur | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Last Period: _____ | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Strokes | <input type="checkbox"/> Cancer: _____ | |
| <input type="checkbox"/> Other _____ | | | <input type="checkbox"/> No Changes | |

Family History

- Kidney Cancer Kidney Stones Heart Disease

Social History

Marital Status: Single Married Divorced Widowed

Smoke: No Yes Occupation: _____ Retired

My Symptom(s) are:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> General/Constitutional | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Ears, Nose, Mouth, Throat | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Nasal Stuffiness | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Change in Bowels |
| <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Chronic Neck Pain | <input type="checkbox"/> Sore Muscles |
| <input type="checkbox"/> Integumentary/Skin | <input type="checkbox"/> Rash | <input type="checkbox"/> Persistent Itching | <input type="checkbox"/> Skin Cancer History |
| <input type="checkbox"/> Neurologic | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Hematologic/Lymphatic | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Transfusion History |