

# 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"/> Enlarged Prostate | <input type="checkbox"/> Blood in urine          | <input type="checkbox"/> High PSA                   | <input type="checkbox"/> Bladder Infection |
| <input type="checkbox"/> Kidney Stones     | <input type="checkbox"/> Prostate Infection      | <input type="checkbox"/> Urinary Incontinence       | <input type="checkbox"/> Bladder Cancer    |
| <input type="checkbox"/> Prostate Cancer   | <input type="checkbox"/> Erectile Dysfunction    | <input type="checkbox"/> Overactive Bladder         | <input type="checkbox"/> Infertility       |
| <input type="checkbox"/> Lump in Testicle  | <input type="checkbox"/> Incomplete Emptying     | <input type="checkbox"/> Frequency                  | <input type="checkbox"/> Intermittency     |
| <input type="checkbox"/> Weak Stream       | <input type="checkbox"/> Straining               | <input type="checkbox"/> Urinating at Night # _____ |  |
| <input type="checkbox"/> Testicle Pain     | <input type="checkbox"/> Pain in Side R / L side | <input type="checkbox"/> Other _____                |  |

**Allergies**  None  Penicillin  Sulfa  Cipro  Iodine/contrast  
 Other \_\_\_\_\_

**Medications** Please list all medications: \_\_\_\_\_

**Surgical History**  Appendectomy  Back/Hip/Knee  Cystoscopy  Gallbladder  
 Heart Bypass  Kidney Stone Surgery  Lithotripsy  Prostate Biopsy  Prostate Seed  
 Prostate Surgery  Other \_\_\_\_\_  **No Changes**

**Medical History**  Diabetes  Emphysema  Heart Attack  Heart Murmur  
 Hepatitis  Hernia  Hypertension  Parkinson's  Strokes  
 Other \_\_\_\_\_  **No Changes**

**Family History**  Prostate Cancer  Kidney Cancer  Kidney Stones  Heart Disease

## Social History

Martial 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 |