

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

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 |