



Huron Valley Urology Associates

HVUA Doctor: _____

Today's Date: _____ New Patient Established Patient

Last Name: _____ First: _____ MI: _____

Date of Birth: _____ Primary Care Provider: _____

Referring Physician: _____ Referred by (Family/Friend): _____

To help us obtain a more comprehensive background, and to better assist you with your medical problems, will you please complete the following:

What is your primary complaint? _____

How long have you had this problem? _____

Do you have difficulty starting/stopping your urine stream? Y N	Has there been a change in size and force of urine stream? Y N
Do you get up at night to urinate? If yes, _____ (# per night)	Do you have difficulty controlling urination? Y N
How often do you urinate during the day? _____ (# of times)	Do you wear a pad or device? Y N

Have you ever had any of the following (circle any and all that apply):			
Blood in urine	Urinary Infection	Kidney Stones	Catheter
If Male:	If Female:	"Female" Cancer? _____	
Do you have difficulty getting an erection? Y N	# of pregnancies: _____	Hormone replacement therapy? Y N	
Do you have difficulty keeping an erection? Y N	# of miscarriages: _____	Birth control method: _____	
Is intercourse satisfactory? Y N	Date of last menstrual period: _____		

Preferred Pharmacy Information

1st Choice: Name of Pharmacy: _____

Address: _____ City: _____

Phone #: _____ Fax: _____

2nd Choice: Name of Pharmacy: _____

Address: _____ City: _____

Phone #: _____ Fax: _____

Patient Name: Last: _____ First: _____ MI: _____ D.O.B _____

Today's Date: _____

Past Surgical History Information: (Please circle all that apply) Check here for "No Surgery Ever"

Surgery	Year	Surgery	Year
ESWL (Lithotripsy)		Prostate Biopsy	
Cystocele/Rectocele		Prostatectomy	
Hysterectomy		TURP	
Nephrectomy (Kidney Removal)		Sling Surgery	
Penile Impant		Urinary Sphincter	
		Vasectomy	

Other Surgeries (Please include All Surgeries): _____

Social History Information:

Tobacco Use? Y N Former Type: _____ Amt/Day: _____ Yrs: _____ (Yr quit: _____)

Alcohol Use? Y N Former Type: _____ How often: _____ (Yr quit: _____)

Caffeine Use? Y N Former Type: _____ How often: _____

Exercise? Y N Type: _____ Times/wk: _____

Marital Status: _____

Number of Children: _____

Employer/Occupation: _____

Family History Information: (Please circle all that apply)

Bladder Cancer	Heart Attack	Kidney Cancer	Kidney Disease	Other:
Colon Cancer	Heart Disease (CAD)	Kidney Stones	Prostate Cancer	Other:

Review of Systems: Have you ever had any of the following in the last 30 days? (Please circle yes or no)

Neurologic Dizziness Y N

Hematologic Bleeding Problems Y N

Endocrine Weight Loss Y N Sweats Y N

Constitutional Generalized Weakness Y N

Musculoskeletal Back Pain Y N Joint Pain Y N

Muscle Weakness Y N

Cardiovascular Chest Pain Y N Ankle Swelling Y N

Respiratory Shortness of Breath Y N

Gastrointestinal Constipation Y N Diarrhea Y N

Blood in Stool Y N

Psychiatric Depression Y N Anxiety Y N

Eyes Visual Changes Y N

Allergic Reaction: Type of Reaction _____

Height: _____ **Weight:** _____

I certify that the information on this form is correct to the best of my knowledge.

Patient Signature: _____ **Date:** _____

For Office Use Only

Reviewed by: _____ Date: _____

Information entered by: _____ (Initials) Date: _____