

**MANCHESTER UROLOGY ASSOCIATES AT DOVER**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

APPOINTMENT DATE: \_\_\_\_\_ MD \_\_\_\_\_

**CHIEF COMPLAINT:**  
(Reason for Today's Visit)

**REFERRING DOCTOR:**  
(Or Primary Care)

**PATIENT MEDICAL HISTORY**  
(PLEASE CHECK)

**FAMILY MEDICAL HISTORY**  
(PLEASE CHECK)

Arthritis/Gout	No	Yes
Bleeding	No	Yes
Cancer	No	Yes
Convulsions	No	Yes
Diabetes	No	Yes
Heart Trouble	No	Yes
Hypertension	No	Yes
Kidney Disease	No	Yes
Stones	No	Yes
Stroke	No	Yes

Arthritis/Gout	No	Yes
Bleeding	No	Yes
Cancer	No	Yes
Convulsions	No	Yes
Diabetes	No	Yes
Heart Trouble	No	Yes
Hypertension	No	Yes
Kidney Disease	No	Yes
Stones	No	Yes
Stroke	No	Yes

**LIST ALL OPERATIONS/SURGERIES AND DATES AND HOSPITALIZATIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIST ALL ALLERGIES**

Allergic to:

Drugs/Medications \_\_\_\_\_

Iodine/Seafood	No	Yes
Latex	No	Yes

**PATIENT SOCIAL HISTORY**

Alcohol                      Never      Rarely      Weekly      Daily

Children                      Sons      Daughters                      None

Street Drugs                      Never      Type/Frequency \_\_\_\_\_

Exposure To:

Toxic Chemicals	No	Yes	Radiation	No	Yes
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Other \_\_\_\_\_

Marital Status (please check)

Single	Married	Separated	Divorced	Widowed
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Tobacco:    Never      Used to, but quit; when \_\_\_\_\_      Pks/day \_\_\_\_\_

**PLEASE LIST YOUR CURRENT**

**Office Use Only**

Height:                      Weight                      // // // //                      BP                      P                      R

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

**REVIEW OF SYSTEMS: Please check YES or NO to All Questions Below****Constitutional**

Good Health Lately	No	Yes
Recent Weight Change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

**Eyes**

Eye Disease of Injury	No	Yes
Glasses/Contacts	No	Yes
Blurred Vision	No	Yes
Glaucoma	No	Yes

**ENT**

Hearing Loss/ringing	No	Yes
Chronic Sinus	No	Yes
Nose Bleeds	No	Yes
Bleeding Gums	No	Yes

**Cardiovascular**

Heart Trouble	No	Yes
Chest Pain/Angina	No	Yes
Palpitations	No	Yes
Swelling of Feet	No	Yes

**Respiratory**

Chronic Cough	No	Yes
Spitting Up Blood	No	Yes
Shortness of Breath	No	Yes
Asthma/Wheezing	No	Yes

**Gastrointestinal**

Loss of Appetite	No	Yes
Change/Bowel Habits	No	Yes
Nausea/Vomiting	No	Yes
Frequent Diarrhea	No	Yes
Frequent Constipation	No	Yes
Rectal Bleeding	No	Yes
Black/Light Stools	No	Yes
Heartburn/Gastritis	No	Yes
Ulcer	No	Yes

**Musculoskeletal**

Joint Pain/Stiffness	No	Yes
Weakness of Muscle	No	Yes
Muscle Pain or Cramp	No	Yes
Cold Extremities	No	Yes
Difficulty Walking	No	Yes

**Integumentary**

Rash or Itching	No	Yes
Varicose Veins	No	Yes
Breast Pain/Discharge	No	Yes
Breast Lump	No	Yes

**Neurological**

Frequent Headaches	No	Yes
Light Headed/Dizzy	No	Yes
Seizures	No	Yes
Numbness/Tingling	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head Injury	No	Yes

**Psychiatric**

Memory Loss/confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

**Endocrine**

Glandular/Hormone Problem	No	Yes
Thyroid Disease	No	Yes
Excessive Thirst/Urination	No	Yes

**Hematological/Lymphatic**

Slow to Heal	No	Yes
Bleeding/Bruising easily	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
History/Blood Transfusion	No	Yes
Swollen Glands	No	Yes

**NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_

**GENTOURINARY**

Frequent urination            No    Yes  
Burning/Painful Urination   No    Yes  
Blood in Urine                No    Yes  
Straining to Urinate         No    Yes  
Incontinence                 No    Yes  
Sexual Difficulty             No    Yes

**WOMEN ONLY**

Painful Periods                No    Yes  
Irregular Periods             No    Yes  
Vaginal Discharge            No    Yes  
Number of Pregnancies \_\_\_\_\_

**LIST ALL MEDICATIONS that you are currently taking or Bring List with you to your appointment**

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**DO YOU TAKE ASPIRIN ON A REGULAR BASIS**                    **No**                    **Yes**

**ADDITIONAL COMMENTS:**