

# UROLOGY ASSOCIATES OF KINGSPORT, P.C.

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Appointment Date \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Date: \_\_\_\_\_

Social Security Number \_\_\_\_\_

Which Doctor in our office are you here to see? \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Why are you seeing the doctor today? \_\_\_\_\_

How long have you had this problem/pain? \_\_\_\_\_

What improves/worsens the problem/pain? \_\_\_\_\_

Are there any symptoms that go along with the problem/pain? \_\_\_\_\_

\_\_\_\_\_

Is the problem/pain continuous, or does it come and go? \_\_\_\_\_

\_\_\_\_\_

What is the nature of the pain? (sharp, dull, etc.) \_\_\_\_\_

Have you tried any medicine/treatment or seen a doctor for this problem before this visit? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Review of Genitourinary Systems

*Please answer Yes (Y) or No (N) if you have or have ever had any of the following:*

Back pain	Y	N	Up at night to urinate	Y	N	Urine Retention	Y	N
Bedwetting	Y	N	Prostate Infection	Y	N	Urologic Cancer	Y	N
Blood in urine	Y	N	Sexual Dysfunction	Y	N	Urologic Surgery	Y	N
Dribbling	Y	N	Sexually Transmitted Diseases	Y	N	Vaginal Bleeding	Y	N
Burning on urination	Y	N	Suprapubic Pain	Y	N	Vaginal Discharge/ Problems	Y	N
Erection/Ejaculation Problems	Y	N	Testes/Scrotal Swelling	Y	N	Weak Stream	Y	N
Flank pain	Y	N	Urgency	Y	N	Other _____		
Kidney Failure	Y	N	Urinary Frequency	Y	N	_____		
Kidney Infections	Y	N	Urinary Hesitancy	Y	N	_____		
Kidney stones	Y	N	Urinary Incontinence	Y	N			
Leak after voiding	Y	N	Urinary Tract Infections	Y	N			

For each of the eight questions below, please check the one box that best describes your symptoms.

The International Scientific Committee (SCI), under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (IJC), has agreed to use the symptom index for BPH, which has been developed by the American Urological Association (AUA) Measurement Committee, as the official worldwide symptoms assessment tool for patients suffering from prostatism.	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	
1. Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None (0)	1 Time	2 Times	3 Times	4 Times	5+ Times	
8. Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

**Past Medical History** Please answer Yes (Y) or No (N) if you have any of the following diseases or conditions:

**CARDIOVASCULAR**

Anemia Y N  
 Angina Y N  
 Aortic Aneurysm Y N  
 Arrhythmia Y N  
 Atrial Fibrillation Y N  
 Bleeding disorder Y N  
 Congestive Heart Failure Y N  
 Deep Vein Thrombosis Y N  
 Heart attack Y N  
 Heart murmur Y N  
 Hypertension Y N  
 Mitral Insufficiency Y N  
 Mitral Valve Prolapse Y N  
 Rheumatic Fever Y N  
 Stroke Y N

**ENDOCRINE / METABOLIC**

Diabetes Melitus Y N  
 Gout Y N  
 Impaired Glucose Tolerance Y N  
 Thyroid Disorder Y N  
**GENERAL**  
 Hepatitis A, B, C Y N  
*(If yes, please circle type)*  
 Sleep Apnea Y N  
 Chronic Fatigue Y N  
**GI**  
 Colitis Y N  
 Constipation Y N  
 Crohn's Disease Y N  
 GERD Y N  
 Hemorrhoids Y N  
 Hiatal hernia Y N

Irritable Bowel Disease Y N  
 Peptic ulcer Y N  
**GU**  
 Bladder infection Y N  
 Kidney disease Y N  
 Kidney infection Y N  
 Kidney Stone Y N  
 Prostatitis Y N  
 Prostate cancer Y N  
 Renal cell cancer Y N  
**MUSCULOSKELETAL**  
 Arthritis  
 Fibromalgia Y N  
 Osteoporosis Y N  
**NEUROLOGICAL/PSYCHOLOGICAL**  
 Alcoholism Y N  
 Alzheimer's disease Y N  
 Anxiety Y N

Depression Y N  
 Epilepsy Y N  
 Migraine Y N  
 Parkinson's Disease Y N  
 Herniated disc Y N  
**RESPIRATORY**  
 Asthma Y N  
 Bronchitis Y N  
 Emphysema Y N  
 Tuberculosis Y N

**OTHER**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Surgical History

Please list all surgeries you have had and note the date:

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## Family History

Please indicate which family member has / had any of the following:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bedwetting _____      | <input type="checkbox"/> Bladder cancer _____ | <input type="checkbox"/> Breast cancer _____     |
| <input type="checkbox"/> Cervical cancer _____ | <input type="checkbox"/> Colon cancer _____   | <input type="checkbox"/> Diabetes mellitus _____ |
| <input type="checkbox"/> Kidney Cancer _____   | <input type="checkbox"/> Kidney Stones _____  | <input type="checkbox"/> Prostate Cancer _____   |

## Social History

### Marital Status

- Single  Married  Separated  Divorced  Widowed  Life Partner  Common Law Spouse

Dependents

Please indicate # of each, if you have living with you:

\_\_\_ Sons \_\_\_ Daughters \_\_\_ Stepchildren \_\_\_ Adopted \_\_\_ Foster \_\_\_ Parents \_\_\_ Grandparents

**Women:** Last Menstrual Period (date): \_\_\_\_\_ Are you pregnant? \_\_\_ Yes \_\_\_ No

**Men and Women:** Are you sexually active  Yes  No

### Occupation:

Please circle one that applies: None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, or Other \_\_\_\_\_

**Alcohol Consumption:** \_\_\_ None \_\_\_ Yes \_\_\_ Occasional/social \_\_\_ # of drinks per day

**Tobacco per day:** \_\_\_ None \_\_\_ Yes \_\_\_ # Packs /day \_\_\_ Cigarettes /day \_\_\_ Smokeless Tobacco  
If you previously stopped, when? \_\_\_\_\_

**Recreational drugs:** \_\_\_ None If yes, please list: \_\_\_\_\_

**Caffeinated beverages:** \_\_\_ None \_\_\_ Low \_\_\_ Moderate \_\_\_ High/Excessive

**Recent Foreign Travel** (please circle all that apply)

None

Americas: Canada, Mexico, Latin America, South America, Other \_\_\_\_\_

World Wide: Europe, Africa, Middle East, Asia, Australia, Other \_\_\_\_\_

## Current Medications

Please list ALL medications you are currently taking. Include any over-the-counter drug (s).

Drug Name	Strength	Directions/How you take it
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**Pharmacy Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Allergies:** Please list ALL types (drug, seasonal, pets, animals, environmental, foods)

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**Review of Systems:** Please answer Yes (Y) or No (N), if you have.

**Constitutional**

- Fever Y N
- Chills Y N
- Hot Flashes Y N
- Night Sweats Y N
- Fatigue Y N
- Weight Loss Y N
- Other \_\_\_\_\_

**Eyes**

- Blindness Y N
- Blurred vision Y N
- Other \_\_\_\_\_

**Neurological**

- Stroke Y N
- Headache Y N
- Dizzy spells Y N
- Numbness/tingling Y N
- Leg or arm weakness Y N
- Memory loss Y N
- Other \_\_\_\_\_

**Endocrine**

- Diabetes Y N
- Pituitary disease Y N
- Thyroid disease Y N
- Other \_\_\_\_\_

**Gastrointestinal**

- Acid reflux Y N
- Indigestion/heartburn Y N
- Nausea/vomiting Y N
- Abdominal pain Y N
- Bloody stools Y N
- Diarrhea Y N
- Constipation Y N
- Rectal bleeding Y N
- Tarry stools Y N
- Other \_\_\_\_\_

**Cardiovascular**

- Chest pain/angina Y N
- Shortness of breath Y N
- Heart attack Y N

- Heart failure Y N
- Heart murmur Y N
- High blood pressure Y N
- Irregular heartbeat Y N
- Other \_\_\_\_\_

**Skin**

- Skin rash Y N
- Other \_\_\_\_\_

**Musculoskeletal**

- Back pains Y N
- Joint pains Y N
- Muscle cramps Y N
- Arthritis Y N
- Osteoporosis Y N
- Other \_\_\_\_\_

**Ears/Nose/Throat**

- Problems swallowing Y N
- Hearing Problems Y N
- Other \_\_\_\_\_

**Respiratory**

- Asthma Y N
- Emphysema-Bronchitis Y N
- Frequent cough Y N
- Shortness of breath Y N
- Other \_\_\_\_\_

**Hematologic/Lymphatic**

- Swollen glands Y N
- Blood clotting problem Y N
- Bleeding problems Y N
- Hepatitis - A, B, or C Y N  
(If yes, please circle type)
- HIV (AIDS) Y N
- Sickle Cell Y N
- Other \_\_\_\_\_

**Psychological**

- Anxious Y N
- Depressed Y N
- Other \_\_\_\_\_

Update \_\_\_\_\_