

KEITH D. NEWMAN, M.D., FACS
UROLOGIC SURGERY

Today's Date: _____ Social Security Number: _____ Age: _____

YOUR Name: _____ DATE OF BIRTH: _____

Are you a New Patient? Yes / No Approximate date of last visit with Dr. Newman. _____

NAMES of OTHER Doctors You See (not Dr. Newman): _____

Your Phone number: _____ Pharmacy Number: _____

Why are you here today

(HPI): _____

Past Urologic problems:

Kidney Stones ; Urologic Tumors ; Urologic Surgery ; Urologic Injuries ; Vasectomy

➔ Medications:

Do you take: Coumadin ; Plavix ; Lovenox ; Aspirin ; Metformin / Glucophage ,
Nitroglycerin/Nitrates ; Lovenox ;

➔➔➔ MEDICATIONS YOU CANNOT TOLERATE

Past Medical Problems:

High Blood Pressure Low Blood Pressure Heart Attack Pacemaker
Diabetes mellitus Stroke TIA Blood Clots

Other Medical Problems:

Surgeries: Gall bladder or Gall stone ; Kidney stones ; Appendix ; Hysterectomy
Circumcision ; Vasectomy ; Bladder Repair / Lift ; Tonsillectomy ; By-Pass

Other Surgeries:

(May continue medications and allergies on the back if necessary)

Do you currently smoke? Yes / No How much _____

Have you smoked? Yes / No How much _____

Do you drink alcohol Yes / No How much _____

Do you take drugs Yes / No How much _____

Are you sexually active Yes / No Problems? _____

Anything Run in your Family:

Your Most Recent Blood pressure _____ / **Your Height** _____ **Your Recent Weight** _____

*******FILL OUT PAGE TWO AS WELL*******

Name: _____ Date: _____

Review Of Systems (Check any that are present in you today)

General: Fever ; Chills ; Weakness ; Decreased Appetite .
Unexplained Weight loss ; Night sweats .

Eyes: Blurred vision ; Double Vision ; Visual Disturbance .

Ears: Hearing loss ; Earache ; Discharge ; Ringing in the ears .

Cardiovascular: Chest pain ; Palpitations ; Sweats ; Calf Pain ;
Shortness of breath when laying down .

Respiratory: Shortness of breath ; Breathing problems on exertion ;
Cough ; Bloody cough .

Gastrointestinal: Abdominal pain ; Nausea ; Vomiting ; Diarrhea ;
Constipation ; Bloody Stools ; Black Tarry stools ; Vomiting Blood .

Neurological: Dizziness ; Lightheadedness ; Fainting ; Seizures ;
Paralysis ; Tingling .

Psychiatric: Anxiety ; Depression ; Suicidal or homicidal Thoughts .

Hematopoietic: Easy bruising ; Bleeding problems ; Anemia .

MALES: Urologic Review of Systems.

Bloody urine ; Burning on urination ; fever ; chills ; flank pain ; stress urinary incontinence ; urge-associated urinary incontinence ; post-void dribbling ; urethral discharge ; Bloody Semen ; Erectile Dysfunction ; visual field defects ; Low libido ; Curvature on Erection ; Pain on Erection ; Pain in the Testicles .

FEMALES: Urologic Review of Systems.

Bloody Urine ; Burning on urination ; fever ; chills ; flank pain ; Urethral Discharge ; Change in period ; Painful intercourse ; Pelvic pain .

1. **Incomplete emptying:** Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

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	Your Score
0	1	2	3	4	5	

2. **Frequency:** Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?

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	Your Score
0	1	2	3	4	5	

3. **Intermittency:** Over the past month, how often have you found that you stopped and started again several times when you urinated?

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	Your Score
0	1	2	3	4	5	

4. **Urgency:** Over the past month, how often have you found it difficult to postpone urination?

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	Your Score
0	1	2	3	4	5	

5. **Weak-stream:** Over the past month, how often have you had a weak stream?

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	Your Score
0	1	2	3	4	5	

6. **Straining:** Over the past month, how often have you had to push or strain to begin urination?

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	Your Score
0	1	2	3	4	5	

7. **Nocturia:** Over the past month or so, how many times did you get up to urinate from the time you went to bed until the time you got up in the morning?

None	1 time	2 times	3 times	4 times	5 or more times	Your Score
0	1	2	3	4	5	

Add up your scores for total AUA score = _____

Quality of Life Due to Urinary Symptoms: 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? (Bold, Highlight or Underline)