University Hospitals
Urology Institute

Health Intake

LAST NAME: _____ FIRST NAME: _____ DOB: _____
Email: _____My Chart Access Invitation: _____Y_____N
Reason for visit: _____

Returning Patients Only:
Any changes in your health or surgeries since last visit? __ YES ___ NO
If YES, please explain:
_____
Any changes in medications? ___ YES ___ NO
If YES, please explain_____

Have you experienced any of the following symptoms?

LIST ANY ALLERGIES

DYE	Y N	LATEX	Y N
IODINE	Y N	SHELL FISH	Y N

MEDICATION ALLERGIES:
_____
_____
_____

MEDICATION (CURRENTLY TAKING)

NAME	AMOUNT	TIMES/DAY
_____		
_____		
_____		
_____		

FAMILY HISTORY

		FAMILY MEMBER
CANCER	Y N	TYPE _____
DIABETES	Y N	_____
HEART DISEASE	Y N	_____
STROKE	Y N	_____
ASTHMA	Y N	_____

LIST ANY PAST SURGERIES

TYPE	DATE/YEAR
_____	
_____	
_____	
_____	

PATIENT MEDICAL HISTORY

		YEAR DIAGNOSED
DIABETES	Y N	_____
HERAT ATTACK	Y N	_____
HYPERTENSION	Y N	_____
HEART MURMUR	Y N	_____
STROKE	Y N	_____
TURBERCULOSIS	Y N	_____
ASTHMA	Y N	_____
ARTHRITIS	Y N	_____
CANCER	Y N	_____

BACK SIDE PLEASE → → →

Constitutional Symptoms

Fever	__Y	__N	Feeling Poorly	__Y	__N	Recent Wt. Gain (___Lbs)	__Y	__N
Chills	__Y	__N	Feeling Tired	__Y	__N	Recent Wt. Loss (___Lbs)	__Y	__N

Eyes

Eye Pain	__Y	__N	Eyesight Problems	__Y	__N	Dry Eyes	__Y	__N
Red Eyes	__Y	__N	Discharge from Eyes	__Y	__N	Eyes Itch	__Y	__N

Ear/Nose/Throat

Earache	__Y	__N	Nosebleeds	__Y	__N	Sore Throat	__Y	__N
Loss of Hearing	__Y	__N	Nasal Discharge	__Y	__N	Hoarseness	__Y	__N

Cardiovascular

Heart Rate is Slow	__Y	__N	Chest Pain	__Y	__N	Leg Claudication	__Y	__N
Heart Rate is Fast	__Y	__N	Palpitations	__Y	__N	Lower Ext Edema	__Y	__N

Respiratory

Wheezing	__Y	__N	Cough	__Y	__N	Orthopnea	__Y	__N
Shortness of Breath (SOB)	__Y	__N	SOB on Exertion	__Y	__N	Postural Nocturnal Dyspnea	__Y	__N

Gastrointestinal

Abdominal Pain	__Y	__N	Nausea	__Y	__N	Vomiting	__Y	__N
Constipation	__Y	__N	Diarrhea	__Y	__N	Bloody Stools	__Y	__N
Heartburn								

Genitourinary

Dysuria	__Y	__N	Hesitancy	__Y	__N	Genital Lesion	__Y	__N
incontinence	__Y	__N	Nocturia	__Y	__N	Testicular Pain	__Y	__N
Genitourinary Symptoms	__Y	__N						

Musculoskeletal

Arthralgias	__Y	__N	Joint Swelling	__Y	__N	Limb Pain	__Y	__N
Myalgias	__Y	__N	Joint Stiffne3ss	__Y	__N	Limb Swelling	__Y	__N
Abnormality of Gait	__Y	__N						

Integumerntary

Skin Rash	__Y	__N	Itching	__Y	__N	Dry Skin	__Y	__N
Skin Lesions	__Y	__N	Skin Wound	__Y	__N	Change in Mole	__Y	__N

Neurologic

Headache	__Y	__N	Numbness	__Y	__N	Tingling	__Y	__N
Confusion	__Y	__N	Dizziness	__Y	__N	Limb Weakness	__Y	__N
Convulsions	__Y	__N	Fainting	__Y	__N	Difficulty Walking	__Y	__N

Psychiatric

Suicidal	__Y	__N	Anxiety	__Y	__N	Change in Personality	__Y	__N
Sleep Disturnances	__Y	__N	Depressioin	__Y	__N	Emotional Problems	__Y	__N
Endocrine	__Y	__N	Erectile Dysfuntion	__Y	__N	Feelings of Weakness	__Y	__N
Proptosis	__Y	__N	Deepening Of the Voice	__Y	__N			
Hot Flashes								

Heme/Lymph

Swollen Glands	__Y	__N	Easy Bleeding	__Y	__N			
Swollen Glands in the Neck	__Y	__N	Easy Bruising	__Y	__N			