**Huong T. Hegde, M.D. • Michael G. Wierschem, M.D.**

**(Please Fill Out Completely)**

Date: ____________________

Home Phone#___________________________

Cell Phone # ____________________________

Work Phone # ___________________________

E-mail: ____________________________ ____

Date of Birth: _____________________ Age:_________ Marital Status: M S D W Male Female

Last Name: _______________________________First:___________________________Middle:_________________

Address: _____________________________________________________________________________________

City:_____________________________________________________State___________ZIP______________________

Patient Employer________________________________________Occupation:_______________________________

Spouse Name__________________________________ Ok to release Medical Information to spouse? Yes No

Emergency Contact_________________________________________Phone:________________________________

Pharmacy Name / Location__________________________________Phone:________________________________

Primary Care Doctor_________________________________________Phone:________________________________

## UROLOGICAL HISTORY:

What is the reason for your visit? ____________________________________________________________________

Who referred you for this condition? (Doctor & Clinic)____________________________________________________

When did this start? ___________________________ Is this the first time you are being seen for this? ________

Do you experience any pain with urination? Y N Are you having any difficulty with urination? Y N

Do you experience any leakage of urine? Y N Have you ever had kidney stones? Y N

Do you have blood in your urine? Y N Are you experiencing any problems with erections? Y N

**Patient Name:**________________________________________________ **Birth date:**_________________________

# MEDICATIONS

Do you take Ibuprofen, Aspirin, Coumadin, Plavix or other **blood thinners**? Yes No

Have you ever been told you needed antibiotics before a procedure? Yes No

Do you have any **drug allergies**? Yes No

If yes, please list below:

**DRUG:** **Type of Reaction:** (rash, nausea, etc)

Are you on any medication (include prescription, over the counter, and herbal supplements) Yes No

If yes, please list all below:

**DRUG:** **DOSE:** **HOW MANY TIMES A DAY:**

Have you ever been or are you now on any of the below medications?

| | | | | |
|---|---|---|---|---|
| Viagra / sildenafil | Levitra / vardenafil | Cialis / tadalafil | Proscar / finasteride | Avodart / dutasteride |
| Uroxatral / alfuzosin | Flomax / tamsulosin | Enablex / darifenacin | Ditropan / oxybutynin | Detrol / tolterodine |
| Vesicare / solifenacin | Cardura / doxazosin | Hytrin / terazosin | Sanctura / trospium chloride | |
| Testosterone | Coumadin / warfarin | Plavix / clopidogrel | Xarelto / rivaroxaban | |

**Patient Name:**________________________________________ **Birth date:**_______________________

## PAST MEDICAL HISTORY

Have you ever had or been treated for any of the following conditions? Yes No

( ) High cholesterol
( ) High blood pressure
( ) Tuberculosis
( ) Glaucoma
( ) Gastroesophageal reflux
( ) Heart attack
( ) Herpes
( ) Heart disease
( ) Mitral Valve prolapse
( ) Diabetes
( ) Gout
( ) Prostatitis
( ) Kidney Infection
( ) Sexually transmitted disease
( ) Mumps
( ) Asthma
( ) Cancer: ___________________
( ) Depression
( ) Blood clot
( ) COPD
( ) HIV

Other:___________________________________________________________________________________

Have you ever had any surgery? No Yes (If yes, please check or write down any surgeries you have had)

( ) Colon
( ) Bladder
( ) Lung
( ) Knee replacement
( ) Prostate
( ) Vasectomy/tubal ligation
( ) Breast
( ) Heart Valve
( ) Inguinal Hernia
( ) Hip replacement
( ) Incontinence
( ) Urinary stone
( ) Thyroid
( ) Angioplasty
( ) Umbilical hernia
( ) Gallbladder
( ) Spleen
( ) Kidney
( ) Hysterectomy
( ) Heart Bypass
( ) Appendectomy
( ) Back
( ) Gastric Bypass
( ) Testicular/Scrotal

Other: __________________________________________________________________________________

Please identify any family history of medical problems. Adopted? Yes No

( ) Heart disease
( ) Kidney tumors
( ) Liver disease
( ) Kidney cysts
( ) Sickle cell
( ) Kidney stones
( ) Diabetes
( ) Cystic fibrosis
( ) Prostate cancer
( ) Bladder cancer
( ) High blood pressure
( ) Other cancer __________
( ) Kidney failure
( ) Anemia
( ) Tuberculosis

Other: __________________________________________________________________________________

## SOCIAL HISTORY

Do you or did you ever smoke? Yes No
If yes, how many packs per day? ________ How many years? ______________
Did you quit? Yes No If yes, when? __________________

Have you or do you use now: Marijuana, cocaine, anabolic steroids, or heroin?

Do you exercise? Yes No
If yes, how much and how often: ____________________________________________

Do you drink alcohol? Yes No
If yes, how much and how often: ____________________________________________

Do you drink caffeine: Yes No Amount per day ___________

Did you or do you ever work around chemicals? Yes No

If yes, please list: __________________________________________________________

For Females: Are you or could you be pregnant? Yes No

**Patient Name:**_______________________________________ **Birth date:**_______________________

# REVIEW OF SYSTEMS

Have you recently had any problems related to the following:

CONSTITUTIONAL

( ) Fever
( ) Chills
( ) Weight change
( ) Headache

EYES

( ) Blindness
( ) Double vision
( ) Blurred vision
( ) Glaucoma open/closed

NEUROLOGICAL

( ) Tremors
( ) Dizziness
( ) Numbness / Tingling
( ) Seizures

ENDOCRINE

( ) Excessive thirst
( ) Tired/sluggish
( ) Too hot/cold
( ) Hair loss

GASTROINTESTINAL

( ) Abdominal pain
( ) Diarrhea
( ) Nausea/vomiting
( ) Constipation
( ) Indigestion/heartburn
( ) Bloating

CARDIOVASCULAR

( ) Chest pain
( ) Palpitations
( ) Irregular heart beat
( ) High blood pressure
( ) Heart failure

INTEGUMENTARY

( ) Skin rash
( ) Boils/sores
( ) Persistent itch

MUSCULOSKELETAL

( ) Joint pain/swelling
( ) Neck pain
( ) Back pain

RESPIRATORY

( ) Cough
( ) Shortness of breath
( ) Wheezing
( ) Cough with blood

IMMUNOLOGICAL

( ) Asthma
( ) Food allergies
( ) Hay fever
( ) Other: _________________

HEMATOLOGIC/LYMPHATIC

( ) Blood clotting problems
( ) Bruising
( ) Anemia
( ) Enlarged lymph nodes

EARS / NOSE / THROAT

( ) Ringing in the ears
( ) Hearing loss
( ) Hoarseness / Sore throat
( ) Recurrent nose bleeds
( ) Ear infection