# CAPITAL UROLOGICAL ASSOCIATES
## Dr. Eric Stockall, M.D.

Patient Name: _______________________________________________________________ Today's Date: __________________

Date of Birth: _______________________ Gender: Male Female Height: ______________ Weight: ________________

Family Doctor: ________________________________ Reason for Today's Visit: _______________________________________

Have you had any recent (last 30 days) lab work completed? Yes No If yes, When? ___________ Where? ___________

Have you ever had any radiology of your abdomen and pelvis? Yes No If yes, When?__________ Where? ___________

**FOR WOMEN:** Date of Last Mammogram: ______________________________________________________________________

**FOR MEN:** Date of Last Rectal Exam: _________________________________ Date of Last PSA Test: ______________________

***REVIEW OF SYMPTOMS*** (please check yes or no is you have any of the following symptoms):

| **GENERAL** | **YES** | **NO** |
|---|---|---|
| Appetite Loss | | |
| Fatigue | | |
| Feeling Well | | |
| Fever | | |
| Weight Loss | | |

| **RESPIRATORY** | **YES** | **NO** |
|---|---|---|
| Cough | | |
| Difficulty Breathing | | |
| Dyspnea (shortness of breath) | | |
| Hemoptysis (coughing up blood) | | |
| Snoring | | |
| Wheezing | | |

| **GASTROINTESTINAL** | **YES** | **NO** |
|---|---|---|
| Abdominal Pain | | |
| Bloody Stool | | |
| Nausea | | |
| Vomiting | | |

| **MUSCULOSKELETAL** | **YES** | **NO** |
|---|---|---|
| Back Pain | | |
| Joint Pain | | |
| Muscle Pain | | |

| **NEUROLOGICAL** | **YES** | **NO** |
|---|---|---|
| Decreased Memory | | |
| Dizziness | | |
| Fainting | | |
| Seizures | | |
| Stroke | | |

| **PSYCHIATRIC** | **YES** | **NO** |
|---|---|---|
| Anxiety | | |
| Depression | | |
| Mood Changes | | |
| Hallucinations | | |

| **ENDOCRINE** | **YES** | **NO** |
|---|---|---|
| Hot Flashes | | |
| Thyroid Problems | | |

| **HEENT** | **YES** | **NO** |
|---|---|---|
| Headache | | |
| Blurred Vision | | |
| Deafness | | |

| **NECK** | **YES** | **NO** |
|---|---|---|
| Neck Pain | | |

| **BREAST** | **YES** | **NO** |
|---|---|---|
| Breast Mass | | |

| **CARDIOVASCULAR** | **YES** | **NO** |
|---|---|---|
| Chest Pain | | |
| Difficulty Breathing Lying Down | | |
| Difficulty Breathing on Exertion | | |
| Hypertension | | |
| Phlebitis (inflammation of vessels) | | |

| **GENITOURINARY** | **YES** | **NO** |
|---|---|---|
| Blood in Urine | | |
| Change in Urinary Stream | | |
| Painful Urination | | |
| Straining to Urinate | | |
| Sensation of Urination but Unable to Go | | |
| Stopping & Starting | | |
| Kidney or Bladder Infection | | |
| Passage of Stones or Gravel | | |
| Lower Back Pain | | |
| Flank Pain | | |
| Frequency | | |
| Hesitancy | | |
| Incontinence | | |
| Menstrual Irregularities | | |
| Nocturia (wake to urinate) | | |
| Painful Intercourse | | |
| Painful Urination | | |
| Pelvic Pain | | |
| Urethral Discharge | | |
| Urgency | | |
| Urinary Retention | | |

| **HEMATOLOGY** | **YES** | **NO** |
|---|---|---|
| Anemia | | |
| Easy Bruising | | |

Patient Name: ______________________________

***PHARMACY***

Preferred Pharmacy: ____________________________________________________________________________

Address: ______________________________________________________________________________________

***CURRENT MEDICATIONS*** (include prescription and over-the-counter, dose, strength and frequency): _________________

______________________________________________________________________________________________

______________________________________________________________________________________________

***ALLERGIES*** (please list all known allergies such as medication, food, environmental, etc.): ____________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

***FAMILY MEDICAL HISTORY*** (check all that apply):

| Symptom/Disease | YOU | Family Member | Indicate Relationship |
|---|---|---|---|
| No History of Disease | | | ________________________________ |
| Asthma | | | ________________________________ |
| Diabetes | | | ________________________________ |
| Heart Disease | | | ________________________________ |
| Hypertension | | | ________________________________ |
| Kidney Stone | | | ________________________________ |
| Stroke | | | ________________________________ |
| Breast Cancer | | | ________________________________ |
| Bladder Cancer | | | ________________________________ |
| Kidney Cancer | | | ________________________________ |
| Prostate Cancer | | | ________________________________ |
| Skin Cancer | | | ________________________________ |
| Other: _______________________ | | | ________________________________ |
| Other: _______________________ | | | ________________________________ |

***SURGICAL HISTORY*** (please list any procedures you have had and the dates): ______________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

| ***SOCIAL HISTORY*** | NONE | YES | HOW MUCH? |
|---|---|---|---|
| Tobacco | | | ________________________________ |
| Alcohol | | | ________________________________ |
| Caffeine | | | ________________________________ |
| Drug Use | | | ________________________________ |
| Narcotics | | | ________________________________ |