Merrimack Urology Associates, P.C.

Name: ______________________________________ ***Date of Birth:*** ____________________

Review of Systems:

Please answer the questions below by Circling either Y = yes or N = no

General

Fatigue	Y / N
Fever	Y / N
Weakness.	Y / N

Ears, Nose, Throat

Bloody nose	Y / N
Ringing in ears. . . .	Y / N
Sinus pain	Y / N
Blurred vision	Y / N

Endocrine

Excessive thirst. . . .	Y / N
Dry mouth	Y / N

Cardiovascular

Chest pain	Y / N
Palpitations.	Y / N

Pulmonary

Cough.	Y / N
Shortness of breath . . .	Y / N

Hematologic

Easy bruising	Y / N
Swollen glands	Y / N

Gastrointestinal

Blood in stool	Y / N
Constipation	Y / N
Diarrhea	Y / N
Heartburn	Y / N

Female reproductive

Vaginal discharge . . .	Y / N
Pelvic pain	Y / N

Male Reproductive

Erectile dysfunction	Y / N
Low sex drive	Y / N

Musculoskeletal

Back pain	Y / N
Joint pain	Y / N
Bone pain	Y / N

Skin

Persistent itching	Y / N
Skin rash	Y / N

Urologic

Blood in urine	Y / N
Frequent urination	Y / N
Incontinence	Y / N

Neurologic

Headache	Y / N
Insomnia	Y / N
Memory loss	Y / N
Neuropathy	Y / N

Psychiatric

Anxiety	Y / N
Depression	Y / N
High stress level	Y / N

Surgical History

Heart or Valve surgery	Y / N
Cardiac stents	Y / N
Vascular surgery or stents . . .	Y / N
Head/Neck or Brain surgery . .	Y / N
Abdominal Surgery	Y / N
Gallbladder	Y / N
Hernia	Y / N
Other	Y / N
Kidney surgery	Y / N
Kidney stone procedures . .	Y / N
Orthopedic Surgery	Y / N
Artificial joints or implants..	Y / N
Hips	Y / N
Knees	Y / N

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Female

GYN surgery:
Uterus/ovaries . . . . Y / N
Cervix/C-section . . . . . Y / N

Male

Scrotal or testicular . . . Y / N
Penile . . . . Y / N
Vasectomy . . . . . Y / N

Medical History

Atrial Fibrillation . . . . . . Y / N
Coronary Disease . . . . . . Y / N
Heart Value Disease. . . . . Y / N
High Blood Pressure . . . . Y / N
High Cholesterol or Lipids . . Y / N
Carotid Artery Disease . . . Y / N
Peripheral Artery Disease . . . Y / N
Kidney Insufficiency . . . . Y / N
Kidney Failure: on Dialysis . . . Y / N
Asthma . . . . Y / N
COPD . . . . Y / N
Diabetes . . . . Y / N
Thyroid Disease . . . . Y / N
Crohn's Disease . . . . Y / N
Ulcerative Colitis . . . . Y / N
Gastric Reflux (GERD) . . . . . Y / N
Spinal Disc Disease . . . . Y / N
Glaucoma . . . . Y / N
Bleeding Disorders . . . . Y / N
History of Cancer?….. Y / N
If so what type?
____
____
Other disease or problem not listed:
____
____

Social History

Occupation: _____________________
Do you smoke? . . . . Y / N
Have you smoked in the past? Y / N
For how long? _________
How much? ___________
Cigarettes . . . . Y / N
Cigars, pipes . . . . . . Y / N
Chewing Tobacco . . . . Y / N

Do you use recreational drugs? Y / N
If yes,
Marijuana . . . . Y / N
Cocaine . . . . Y / N
IV drugs . . . . Y / N
Other . . . . Y / N

Do you drink alcohol? Y / N
How much?_________
Beer _____ Wine _____Liquor _____
If formerly, year quit _______

Caffeine:
Coffee, tea, soda, energy drinks?
How much per day? _______

Family History

Father – Alive . . . . Y / N
Mother – Alive . . . . Y / N
Children – Alive . . . Y / N
Siblings – Alive . . . . Y / N

Has any blood **relative** had:
Diabetes . . . . Y / N
High Blood Pressure . Y / N
Heart Disease . . . Y / N
Stroke . . . . . Y / N
Mental Illness . . . . . Y / N
Cancer . . . . Y / N
What type: ________________

Signature: ________________________

Date: ________________________