ISLAND UROLOGY
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1015 25th Street, Upper Level
Anacortes, WA 98221
(360) 299-4980

Dear _____,

It is our pleasure to welcome you to our practice. We are sending you some information prior to your appointment in order for your first visit to be as efficient as possible. Please fill out the patient data sheet and health history form and bring them with you. We will also need a urine specimen at the time of your visit, so please do not empty your bladder before your appointment!

Your appointment is scheduled for _____ at _____.

Please check in at _____.

Please be sure to have your insurance information with you for this appointment. If your insurance requires a co-pay, we ask that you pay it at the time of service. If a referral authorization is required, please make sure you contact your primary care provider prior to your scheduled visit. All self-pay patients will be required to pay for the visit in full at the time of service

If you have any questions, please call our office at (360) 299-4980.

Sincerely,
Island Urology

ISLAND UROLOGY – ADULT HEALTH HISTORY FORM

Island Urology
1015 25th Street, Upper Level
Anacortes, WA 98221
(360) 299-4980

Patient Name: _____ **Phone:** _____

Age: _____ **Date of Birth:** _____ **Height:** _____ft _____in **Weight:** _____lbs

Referring Provider: _____ **Phone:** _____

Primary Care Provider: _____ **Phone:** _____

Sex: ☐ M ☐ F **Race:** ☐ White ☐ Black ☐ Asian ☐ Hispanic/Latino ☐ Other _____

Reason for Visit Today: _____

Pharmacy Name: _____ **City:** _____ **Phone:** _____

Drug Allergies: _____

Other Allergies: _____

CURRENT MEDICATIONS: Please list any prescription medications, over-the-counter medications and vitamin supplements you take routinely.

Name of Drug or Supplement	Strength (mg)	How often (# of times per day)

MEDICAL HISTORY: Please check any of the following conditions which **YOU** have had or presently have:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ BPH
- ☐ Cancer
  Type: _____
- ☐ Chest Pain
- ☐ CVA (Stroke)
- ☐ Chronic UTIs
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular Disease
- ☐ GERD
- ☐ Gout
- ☐ Hepatitis C
- ☐ Hypercholesterolemia
- ☐ Hyperlipidemia
- ☐ High Blood Pressure
- ☐ Inflammatory Bowel
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Heart Attack
- ☐ Neurologic Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Renal/Kidney Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Thyroid Disease
- ☐ Valvular Heart Disease

FEMALES ONLY: **Date of last menstrual period:** _____/_____/_____ **Date of last PAP smear:** _____/_____/_____

SURGICAL HISTORY: Please check any of the following procedures you have had performed and the date of the procedure:

	Yr		Yr		Yr	FEMALES Only	Yr	MALES Only	Yr
☐ Adrenalectomy		☐ Cystoscopy		☐ Liver Biopsy		☐ Bladder Suspension		☐ Brachytherapy	
☐ Appendectomy		☐ ESWL		☐ Kidney Removed		☐ Breast Biopsy		☐ Circumcision	
☐ Back Surgery		☐ Gastric Bypass		☐ Pacemaker		☐ C-Section		☐ Hydrocelectomy	
☐ Bladder Augmentation		☐ Hernia Repair		☐ Perc Stone Removal		☐ Abdominal Hyst		☐ Laser of Prostate	
☐ CABG		Type:_____		☐ Kidney Stone Removal		☐ Mastectomy		☐ Orchiectomy	
☐ Gallbladder		_____		☐ Ureteral Stents		☐ Vaginal Sling		☐ Penile Prosthesis	
☐ Colectomy		☐ Hip Replacement		**Other:**		☐ TAH / BSO		☐ Prostate Biopsy	
☐ Colon Surgery		☐ Knee Replacement		☐		☐ Tubal Ligation		☐ Prostatectomy	
☐ Coronary Stent		☐ Laparoscopy		☐		☐ Vaginal Hyst		☐ Spermatocelectomy	
☐ Bladder Removal		☐ Lithotripsy		☐				☐ TURP	
								☐ Varicocele Ligation	
								☐ Vasectomy	

CHRONIC PROBLEMS LIST: Please list any chronic health problems you have.

ISLAND HEALTH

ISLAND UROLOGY – ADULT HEALTH HISTORY FORM

Problem	Date of onset	Treatment

FAMILY HISTORY: Please check any of the following conditions that apply to your family members and list their relation to you.

Diagnosis	Yes	No	Relationship	Diagnosis	Yes	No	Relationship
Blood Disease				High Cholesterol			
BPH				High Blood Pressure			
Cancer				Inflammatory Bowel Disease			
Type:				Migraines			
CVA / Stroke				Renal Failure			
Coronary Artery Disease				Seizure Disorder			
Diabetes				Thyroid Disorder			
Eczema				Urinary Tract Infections			
Gout				Kidney Stones			
Hearing Impairment				Other:			
Other:							

Marital / Family Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed Previously widowed? ☐ Yes ☐ No Previous divorce? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No If yes, number: _____

LIFESTYLE:

Occupation: _____

Exercise? ☐ Yes ☐ No If yes, type: _____ Frequency: _____per_____ Hours per week:_____

TOBACCO:

Uses tobacco? ☐ Yes ☐ No ☐ Former Tobacco type: _____ Units per day: _____ Number of years:_____

If former user: Units per day: _____ Number of years: _____ Year quit: _____

CAFFEINE: ☐ Yes ☐ No Type: _____,_____ Amount Daily: _____

ALCOHOL: ☐ Yes ☐ No ☐ Formerly, Year quit: _____ Type: _____ Frequency: _____

Amount: _____per_____ Last drink: _____

REVIEW OF SYSTEMS: Please mark all Yes or No

Constitutional-☐Neg	Respiratory-☐Neg	Gastrointestinal-☐Neg	Metabolic/Endocrine-☐Neg	Musculoskeletal-☐Neg
No Yes ☐ ☐ Chills ☐ ☐ Fever	No Yes ☐ ☐ Dyspnea (shortness of breath)	No Yes ☐ ☐ Diarrhea	No Yes ☐ ☐ Goiter	No Yes ☐ ☐ Back pain
Heent-☐Neg	**Cardiovascular-☐Neg**	**Integumentary-☐Neg**	**Neurological-☐Neg**	**Hema/Lymphatic-☐Neg**
No Yes ☐ ☐ Double vision	No Yes ☐ ☐ Chest pain	No Yes ☐ ☐ Rash	No Yes ☐ ☐ Dizziness	No Yes ☐ ☐ Easy bleeding ☐ ☐ Petechiae/easy bruising
		Psychiatric-☐Neg		
		No Yes ☐ ☐ Anxiety		

11 System ROS

☐ **All Negative**

Patient Name: _____ **Phone:** _____

ISLAND HEALTH

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Patient Address: _____

E-mail Address: _____

Responsible Party/Relationship: _____ **Phone:** _____

Responsible Party Address: _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Not Provided **Language:** ☐ English ☐ Spanish ☐ Russian ☐ Other

Name of Spouse: _____ **Business Phone:** _____

Emergency Contact: _____ **Phone:** _____

Primary Insurance: _____ **ID #:** _____

Subscriber: _____ **Date of Birth:** _____ **Group #:** _____

Secondary Insurance: _____ **ID #:** _____

Subscriber: _____ **Date of Birth:** _____ **Group #:** _____

ISLAND HEALTH

Patient Name: _____ **Date:** _____

The following questions are related to your bladder symptoms or pelvic/vaginal pressure, and its impact upon you.

1. Overall, how frustrated are you with your bladder control?

☐ Not at all ☐ Slightly ☐ Somewhat ☐ Moderately ☐ Greatly

2. How much has this problem affect your emotional health? (Depressed mood, nervousness, unwilling to leave the house, etc.)

☐ Not at all ☐ Slightly ☐ Somewhat ☐ Moderately ☐ Greatly

3. How has your bladder problem affected your ability to exercise or work?

☐ Not at all ☐ Slightly ☐ Somewhat ☐ Moderately ☐ Greatly

4. Do you feel that you empty your bladder completely after voiding? If not, how much does it bother you?

☐ Not at all ☐ Slightly ☐ Somewhat ☐ Moderately ☐ Greatly

5. How frequently do you usually need to go to the bathroom to urinate during the day?

☐ Every hour ☐ Two hours ☐ Three hours ☐ Four hours ☐ More than four

6. If you do go to the restroom frequently, how much does it bother you?

☐ Not at all ☐ Slightly ☐ Somewhat ☐ Moderately ☐ Greatly

7. When you need to use the restroom, do you often need to hurry or can you take your time and go when you want to?

☐ Hurry ☐ Take time

8. If you have a strong urge to urinate, could you possibly leak prior to reaching the restroom?

☐ Yes ☐ No

How much does this bother you?

☐ Not at all ☐ Slightly ☐ Somewhat ☐ Moderately ☐ Greatly

9. How many times do you need to get up during the night to go to the bathroom? _____

10. How bothered are you by urine leakage related to physical activity?

☐ Not at all ☐ Slightly ☐ Somewhat ☐ Moderately ☐ Greatly

Check all activities which result in accidental leakage:

Coughing	☐	Sneezing	☐	Jumping	☐
Laughing	☐	Exercising	☐	Bending	☐

11. Do you have more bladder infections than you believe you should?

☐ Yes ☐ No