NAME: _____ DOB: _____

UROLOGY

PLEASE COMPLETE BUBBLE SHEET THOROUGHLY

Urology
Frequent urination	O Yes O No
Urgent need to urinate	O Yes O No
Pain with urination	O Yes O No
Nighttime urination	O Yes O No
Difficulty starting urinary stream	O Yes O No
Leakage or dribbling	O Yes O No
Reduced flow	O Yes O No
Blood in urine	O Yes O No
Straining to urinate	O Yes O No
Pelvic pain	O Yes O No
Sexual difficulty	O Yes O No
Female-infertility	O Yes O No
Female-irregular periods	O Yes O No
Female- vaginal discharge	O Yes O No

Other: _____

Male Reproductive
Difficulty with erection	O Yes O No
Difficulty with ejaculation	O Yes O No
Diminished sexual drive	O Yes O No

Other: _____

Cardiology
swelling of feet, ankles, or hands	O Yes O No
shortness of breath	O Yes O No
chest pain at rest	O Yes O No
Chest pain with exertion	O Yes O No
Dizziness	O Yes O No
Irregular heartbeat	O Yes O No
Palpitations	O Yes O No

Other: _____

Dermatology
Scars	O Yes O No
Rash	O Yes O No
Dry or Sensitive Skin	O Yes O No
Hives	O Yes O No
Acne	O Yes O No
Skin cancer	O Yes O No

Other: _____

Endocrinology
Fatigue	O Yes O No
Excessive Thirst	O Yes O No
Excessive Urination	O Yes O No
Cold Intolerance	O Yes O No
Hot flashes	O Yes O No
Weight Loss	O Yes O No

Other: _____

ENT
difficulty swallowing	O Yes O No
Sore throat	O Yes O No
Cough	O Yes O No
Sinus Problems	O Yes O No
hearing loss/hard of hearing	O Yes O No
nose bleeds	O Yes O No
Tinnitis (ringing in ear)	O Yes O No

Other: _____

Gastroenterology
black/tarry stools	O Yes O No
diarrhea	O Yes O No
abdominal pain	O Yes O No
nausea/vomiting	O Yes O No
Heartburn / indigestion	O Yes O No
blood in stool	O Yes O No
Constipation	O Yes O No

Other: _____

General
fever	O Yes O No
Chills	O Yes O No
fatigue	O Yes O No
weakness	O Yes O No
weight loss	O Yes O No
weight gain	O Yes O No

Other: _____

Hematologic/Lymphatic
excessive bleeding w/dental work	O Yes O No
easy bruising	O Yes O No
swollen glands	O Yes O No
loss of appetite	O Yes O No

Other: _____

Musculoskeletal
fracture	O Yes O No
back pain	O Yes O No
Bone pain	O Yes O No
Muscle weakness	O Yes O No
Joint swelling, stiffness, pain	O Yes O No

Other: _____

Neurology
Insomnia	O Yes O No
Dizziness	O Yes O No
Weakness	O Yes O No
Headache	O Yes O No
Numbness	O Yes O No
Seizures/Convulsions	O Yes O No
Leg weakness	O Yes O No

Other: _____

Ophthalmology
blurring of vision	O Yes O No
eye drainage	O Yes O No
eye irritation, pain	O Yes O No
loss of vision	O Yes O No
Spots in vision	O Yes O No

Other: _____

Respiratory
Shortness of breath	O Yes O No
Need for home oxygen	O Yes O No
Chest pain	O Yes O No
Cough	O Yes O No
Chronic/Frequent cough	O Yes O No
Difficulty breathing at rest	O Yes O No
Difficulty breath on exertion	O Yes O No

Other: _____