Parkland Medical Center

Lahey CLINIC

Urology New Patient History Form

One Parkland Drive • Derry, NH 03038 • (603) 432-1500
www.parklandmedicalcenter.com

Name: _____ Height: _____
Birthdate (mm/dd/yyyy): _____ Weight: _____
Age: _____ Referred by: _____
Gender: ☐ Male ☐ Female Primary Care Physician: _____

WHAT IS THE REASON FOR YOUR VISIT TODAY?

PAST MEDICAL HISTORY: Please list ***prior and current medical history***, even if your medications have fixed the problem (examples: high blood pressure, high cholesterol, asthma, heart attack, depression, etc).

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

PAST SURGICAL HISTORY: Please ***list prior surgeries with approximate dates***, no matter how long ago (examples: appendectomy, gall bladder removal, tonsillectomy, hip or knee surgery, etc).

OPERATION	*YEAR*	*REASON*
1.		
2.		
3.		
4.		
5.		

Do you have ALLERGIES to medication, food, latex, adhesives? ☐ **Yes** ☐ **No**
If yes, please explain:

List **CURRENT MEDICATIONS:** dosage & frequency (including aspirin, advil, and vitamins)

1. 5.
2. 6.
3. 7.
4. 8.

SOCIAL HISTORY
Marital status: _____
Occupation: _____
Number of children? _____
Do you drink alcohol? ☐ Yes ☐ No
Alcohol intake: ☐ occasional ☐ 1-2 per day ☐ 3-4 per day ☐ 5-6 per day ☐ >6 per day

Do you smoke currently?
If you quit, what year? _____
Prior to quitting, # packs per day? _____
How many years did you smoke? _____
Recreational drug use? ☐ Yes ☐ No

FAMILY HISTORY: List all serious family medical illnesses or cancers (father, mother, siblings, your children). Examples: high blood pressure, stroke, heart attack, diabetes, prostate cancer.

1. 5.
2. 6.
3. 7.
4. 8.

Patient Information/Label

If you are having ***pain related to your visit today***, please rate it by circling on the scale below, with "0" being no pain, and "10" being excruciating pain:

☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

How would you describe the pain? _____

What makes it worse? _____

What makes it better?

OTHER: **Unexpected** weight loss greater than 10#s ☐ Yes ☐ No

Have you fallen in the past 6 months? ☐ Yes ☐ No

I learn better by: ☐ Hearing ☐ Reading ☐ Seeing pictures ☐ All

I have suffered abuse in the last year ☐ Yes ☐ No

I need help with: ☐ Dressing ☐ Bathing ☐ Driving ☐ None

REVIEW OF SYSTEMS

Have you had any of the following in the last 12 months?

CONSTITUTIONAL		
Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No
Unexpected weight loss	☐ Yes	☐ No
EYES / EARS / NOSE / THROAT		
Blurred or double vision	☐ Yes	☐ No
Eye pain	☐ Yes	☐ No
Ear infection	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
CARDIOVASCULAR		
Chest pain or angina	☐ Yes	☐ No
Palpitations / irregular beat	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Ankle or foot swelling	☐ Yes	☐ No
Leg pain with walking	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
PULMONARY		
Shortness of breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Frequent cough	☐ Yes	☐ No
Coughing blood	☐ Yes	☐ No
HEMATOLOGICAL		
Anemia	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No
Easy bleeding	☐ Yes	☐ No
SKIN		
Persistent Itch	☐ Yes	☐ No
New Lesion / Rash	☐ Yes	☐ No
PSYCHOLOGICAL		
Generally happy with life?	☐ Yes	☐ No
Severe depression	☐ Yes	☐ No
Considered suicide	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Difficulty sleeping	☐ Yes	☐ No

GASTROINTESTINAL		
Heartburn / Acid reflux	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Nausea and/or vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
ENDOCRINE		
Excessive thirst	☐ Yes	☐ No
Too hot or too cold	☐ Yes	☐ No
Blood sugar problems	☐ Yes	☐ No
Irregular menstrual cycles	☐ Yes	☐ No
MUSCULOSKELETAL		
Joint pain	☐ Yes	☐ No
Neck pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
NEUROLOGICAL		
Numbness or tingling	☐ Yes	☐ No
Arm/Leg weakness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
GENITOURINARY		
Blood in urine	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No
Difficult urination	☐ Yes	☐ No
Urinary infection	☐ Yes	☐ No
LYMPHATIC		
Swollen glands	☐ Yes	☐ No
Swelling of arms/legs	☐ Yes	☐ No
ALLERGY / IMMUNOLOGY		
Hay fever	☐ Yes	☐ No
Frequent infections	☐ Yes	☐ No

OTHER

Anything else you would like to add?

Reviewed by: _____ Date/Time: _____

Patient Information/Label

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IIQ and UDI

__ / __ / ____
MM DD YY

Incontinence Impact Questionnaire

Has urine leakage affected your: ("X" one for each question)

	Not at all	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐	☐	☐	☐
2. Physical recreation such as walking swimming or other exercise?	☐	☐	☐	☐
3. Entertainment activities (movies, concerts, etc.)?	☐	☐	☐	☐
4. Ability to travel by car or bus more than 30 minutes from home?	☐	☐	☐	☐
5. Participation in social activities outside your house?	☐	☐	☐	☐
6. Emotional health (nervousness, depression, etc.)?	☐	☐	☐	☐
7. Feeling frustrated?	☐	☐	☐	☐

Urogenital Distress Inventory

Do you experience, and if so, How much are you bothered by: ("X" one for each question)

	Not at all	Slightly	Moderately	Greatly
1. Frequent urination?	☐	☐	☐	☐
2. Urine leakage related to the feeling of urgency?	☐	☐	☐	☐
3. Urine leakage related to physical activity, coughing, or sneezing?	☐	☐	☐	☐
4. Small amounts of urine leakage drops?	☐	☐	☐	☐
5. Difficulty emptying your bladder?	☐	☐	☐	☐
6. Pain or discomfort in the lower abdominal or genital area?	☐	☐	☐	☐

Patient Information/Label

1. Do you have any uncontrolled leakage of gas, liquid, or solid stool?

   ____ Yes ____ No

   If yes, mark which apply

   ____ gas
   ____ liquid stool
   ____ solid stool

2. On a scale of 0 to 100, where zero represents death and 100 represents perfect health, please indicate how you would rate your current state of health.

   ____ ____ ____ Number from 0-100

Patient Information/Label