Weill Cornell Medicine
Urology
Douglas Scherr, MD
212-746-5788

Name: _____
Date of Birth: _____
Date: _____

CHIEF COMPLAINT

What is the **main reason** for your visit today**?**

ALLERGIES

Are you allergic to any of the following? Please check **YES** or **NO** for each.

☐ Check here if you have **NO** known allergies.

Allergen	Yes	No	Reaction
Penicillin	☐	☐	
Sulfa	☐	☐	
Latex	☐	☐	
IV Contrast Dye	☐	☐	
Cipro/Levaquin	☐	☐	
Macrobid/Nitrofurantion	☐	☐	
Others (please list)	☐	☐	

MEDICATIONS

Please list the **name, dosage and frequency** of all medications you are taking (include regularly used over-the-counter medications/supplements). **IF YOU HAVE A MEDICAL LIST WITH YOU, PLEASE SUBMIT IT WITH THIS FORM.**

☐ Check here if you are currently taking **NO** medications.

Medication	Dose	How Often?

SURGICAL HISTORY

Have you ever had any of the following **surgeries or procedures?** Please check **YES or NO** for each.

☐ Check here if you have had **NO** surgeries or procedures.

Urologic Surgeries	Yes	No	Date
Kidney surgery	☐	☐	
Bladder or Incontinence surgery	☐	☐	
Males Only			
Scrotal/Testicle surgery	☐	☐	
Penis surgery	☐	☐	
Other:	☐	☐	

Gynecological Surgeries (Females only)	Yes	No	Date
Hysterectomy	☐	☐	
C-Section (Number of deliveries: _____)	☐	☐	
Other:	☐	☐	

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Abdominal Surgeries	Yes	No	Date
Appendix removal	☐	☐	
Gallbladder removal (cholecystectomy)	☐	☐	
Hernia surgery	☐	☐	
Groin (inguinal)? Side?	☐	☐	
Navel (umbilical)?	☐	☐	
Removal of bowel	☐	☐	
Bag for drainage of stool (ostomy)?	☐	☐	
Aneurysm repair	☐	☐	
Other:	☐	☐	

Brain, Head or Neck Surgeries	Yes	No	Date
Carotid surgery	☐	☐	
Other:	☐	☐	

Chest Surgeries	Yes	No	Date
Heart bypass	☐	☐	
Artificial heart valve	☐	☐	
Other:	☐	☐	

Joint or Bone Surgeries	Yes	No	Date
Artificial joint/replacement? Which one?	☐	☐	
Orthopedic procedures?	☐	☐	
Other:	☐	☐	

Other Surgeries (Please List)	Date
_____	_____
_____	_____
_____	_____

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PAST MEDICAL HISTORY

Have you ever been treated for any of the following **medical problems?** Please check **YES** or **NO** for each.

Condition	Yes	No
Adrenal Problems	☐	☐
Asthma/Emphysema	☐	☐
Blood Clots/Bleeding Problems/Deep Vein Thrombosis/Pulmonary Embolus	☐	☐
Cancers (please list):	☐	☐
Cataracts	☐	☐
Congestive Heart Failure	☐	☐
Diabetes	☐	☐
Gastrointestinal Bleeding	☐	☐
Glaucoma	☐	☐
Gout	☐	☐
Heart Attack/Stroke	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
HIV/AIDS	☐	☐
Irregular Heart Beat	☐	☐
Kidney Failure	☐	☐
Kidney Stones	☐	☐
Mumps	☐	☐
Sleep Apnea	☐	☐
Thyroid Disease	☐	☐
Tuberculosis	☐	☐
Urinary Infections	☐	☐
Females Only: • Number of Pregnancies: ____ • Number of Miscarriages: ____		
Other (please list):	☐	☐

FAMILY HISTORY

Do you have any **close relatives** with any of the following conditions or do any of the following conditions **run in your family**? Please check **YES** or **NO** for each.

Condition	Yes	No
Prostate Cancer	☐	☐
Bladder Cancer	☐	☐
Kidney Cancer	☐	☐
Kidney Stones	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	☐
Other Cancers	☐	☐
Other (please list):	☐	☐

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SOCIAL HISTORY

Please check or fill in the appropriate answer for each question.

Question	Answer
What is your marital status?	☐ Married ☐ Single ☐ Divorced ☐ Separated
Do you smoke?	☐ Yes, Daily ☐ Yes, Not Daily ☐ Not Anymore ☐ Never Smoked
If yes, what do you smoke?	☐ Cigar ☐ Cigarettes ☐ Vaporizer ☐ Marijuana
How long have you smoked? _____	How many packs per day? _____
When did you quit? _____	
Do you use any of the following:	☐ Chewing tobacco/snuff ☐ Edible marijuana ☐ Illegal substances (drugs)
Do you drink alcohol?	☐ Yes ☐ No ☐ Not anymore
How much do you drink per week?	
What do you drink?	☐ Beer ☐ Wine ☐ Liquor
When did you quit?	
How many caffeinated beverages do you have per day?	
Have you ever had a blood transfusion?	
What is your primary language?	☐ English ☐ Japanese ☐ German ☐ French ☐ Chinese ☐ Russian ☐ Spanish ☐ Italian ☐ Portuguese ☐ Other:
What is your race?	☐ White ☐ Other: ☐ Hispanic/Latino ☐ Asian ☐ American Indian/Alaskan Native ☐ Black/African American ☐ Native Hawaiian /Pacific Islander
What do you do for a living (what is your occupation)? _____	

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REVIEW OF SYSTEMS

☐ Check here if you have no problems in any areas

Constitutional	Yes	No
Fever	☐	☐
Chills	☐	☐
Weight Loss	☐	☐

Eyes	Yes	No
Blurry Vision	☐	☐
Double Vision	☐	☐
Cataracts	☐	☐

Ears, Nose, Mouth, Throat	Yes	No
Hearing Loss	☐	☐
Nasal Stuffiness	☐	☐
Sore Throat	☐	☐

Cardiovascular	Yes	No
Chest Pain	☐	☐
Swollen Ankles	☐	☐
Irregular Heart Beat	☐	☐
Pacemaker	☐	☐
Internal Defibrillator	☐	☐
Coronary Stents	☐	☐
Angiocaths	☐	☐

Respiratory	Yes	No
Shortness of Breath	☐	☐
Wheezing	☐	☐
Chronic Cough	☐	☐

Gastrointestinal	Yes	No
Abdominal Pain	☐	☐
Nausea/Vomiting	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐

Musculoskeletal	Yes	No
Chronic Back Pain	☐	☐
Chronic Neck Pain	☐	☐
Sore Muscles	☐	☐

Integumentary, Skin	Yes	No
Rash	☐	☐
Persistent Itchiness	☐	☐
Skin Cancer History	☐	☐

Neurological	Yes	No
Numbness	☐	☐
Dizziness	☐	☐
Tingling	☐	☐

Hematological, Lymphatic	Yes	No
Swollen Glands	☐	☐
Abnormal Bleeding	☐	☐
Bruise Easily	☐	☐

Endocrine	Yes	No
Chronic Fatigue	☐	☐
Chronically too Hot/Cold	☐	☐
Excessive Thirst	☐	☐

Respiratory	Yes	No
Shortness of Breath	☐	☐
Wheezing	☐	☐
Chronic Cough	☐	☐

Sexual Function	Yes	No
Sexually Active	☐	☐
Decreased Erections	☐	☐
Ejaculation Issues	☐	☐
Decreased Libido	☐	☐

Other: _____

I have read and answered all of the questions in their entirety and the information is accurate and true to the best of my knowledge.

_____ _____
Signature Date