Bradley W. Rupp, M.D.
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Patient History and Physical Form

Patient Name:____ Date of Birth:_____________________

Chief Complaint:____

Patient Signature:____ Date:__________________________

Personal Medical History

Medical: (__None) Otherwise, list all past serious illnesses and approximate date. (Examples: HBP, Diabetes, Cancer, Heart Disease)

____

Surgery: (__None) Otherwise, list type and approximate year> (Examples: Heart, Hernia, Appendectomy)

____

Current Prescription Medications: (__None) ***If questions, please bring medication bottles with you.***

Name of Medication	Dose	Name of Medication	Dose
1. ______________________		5. ______________________	
2. ______________________		6. ______________________	
3. ______________________		7. ______________________	
4. ______________________		8. ______________________	

Over the counter medicines: (Example: Aspirin, Tylenol, vitamins, herbals) ______________________________________

Allergies: (__None that I know of)

I am allergic to: (If yes, please explain the type of reaction, i.e., hives, wheezing, upset stomach, selling, etc.)

__ Latex __ Shellfish __ Iodine or X-Ray Dye __ Penicillin __ Sulfa Drugs __ Aspirin __ Antibiotics

Other/Explain:____

Past Family History of Disease

Family History of:		Yes	No	Family Member	Family History of:		Yes	No	Family Member
1.	Heart Disease				6.	Bladder Cancer			
2.	Kidney Disease				7.	Kidney Cancer			
3.	Kidney Stones				8.	Prostate Cancer			
4.	Diabetes				9.	Stroke			
5.	Bleeding Problems				Other:				

Social History

Do you smoke?	Yes	No	If yes, more than 1½ packs per day?	Yes	No
Do drink alcohol?	Yes	No	If yes, more than 6 drinks per week?	Yes	No

How many glasses of water do you usually drink every day? ________________

How many cups of coffee/tea or caffeinated drinks do you usually drink every day? ________________

Urology History (Circle One)

1. Burning with urination	Yes	No	7. Need to urinate frequently	Yes	No
2. Notice blood in urine	Yes	No	8. Urine leakage (Incontinence)	Yes	No
3. Urgency to urinate (feels like you have an urgent need to urinate)	Yes	No	9. Get up at night to urinate. If yes, how many times? ________	Yes	No
4. Hesitancy starting to urinate	Yes	No	10. History of kidney stones	Yes	No
5. Unable to completely empty bladder	Yes	No	11. Felt lumps in genitalia	Yes	No
6. Unable to urinate at all	Yes	No			

Review of Systems:

Constitutional Systems			Cardiovascular			Endocrine		
Fever/Chills	Yes	No	Chest Pain	Yes	No	Excessive Thirst	Yes	No

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Bad Headaches	Yes	No	Swelling in Ankles	Yes	No	Too hot/Too cold	Yes	No
Weight/Appetite Change	Yes	No	High Blood Pressure	Yes	No	Tired/Sluggish	Yes	No
Other:___________________________			Other:___________________________			Other:________________________		

Review of Systems Continued:

Respiratory			**Hematologic/Lymphatic**			**Ear/Nose/Throat/Mouth**		
Wheezing	Yes	No	Swollen Glands	Yes	No	Ear Infection	Yes	No
Frequent Cough	Yes	No	Blood Clotting Problems	Yes	No	Sore Throat	Yes	No
Shortness of Breath	Yes	No	Excessive Bruising	Yes	No	Sinus Problem	Yes	No
Other:___________________________			Other:___________________________			Other:________________________		
Neurological			**Gastrointestinal**			**Musculoskeletal**		
Tremors	Yes	No	Abdominal Pain	Yes	No	Joint Pain	Yes	No
Dizzy Spells	Yes	No	Nausea/Vomiting	Yes	No	Neck Pain	Yes	No
Numbness/Tingling	Yes	No	Indigestion/Heartburn	Yes	No	Back Pain	Yes	No
Stroke	Yes	No	Constipation/Diarrhea	Yes	No	Loss of Strength	Yes	No
Other:___________________________			Other:___________________________			Other:________________________		
Allergic/Immunologic			**Eyes**			**Psychological**		
Hay Fever	Yes	No	Blurred Vision	Yes	No	Depression	Yes	No
Drug Allergies	Yes	No	Double Vision	Yes	No	Anxiety over Condition	Yes	No
Other:___________________________			Other:___________________________			Other:_________________________		

Integumentary

Skin Rash	Yes	No
Boils	Yes	No
Persistent Itch	Yes	No
Other:___________________________		

Females Only:

Pregnancy History (if applicable):
Number of Pregnancies:_________
Number of Vaginal Deliveries:_________
Hysterectomy Age:

Males Only: Prostate System Score

Over the Past Month	Not at all	Less than 1 time in 5	Less than ½ the time	About ½ the time	More than ½ the time	Almost Always
Incomplete Emptying: How often have you had the sensation of not emptying your bladder completely after you have finished urinating?	0	1	2	3	4	5
Frequency: How often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
Intermittency: How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency: How often do you find it difficult to postpone urination?	0	1	2	3	4	5
Weak Stream: How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining: How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping: How many times do you most typically get up to urinate from the time you go to bed at night until the time you get up in the morning?	0	1	2	3	4	5
Add Symptom Scores:						

Total Prostate Symptom Score = __________

1-7 mild symptoms | 8-19 moderate symptoms | 20-35 severe symptoms

Quality of Life (QoL)	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible

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How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

Have you tried medications to help your symptoms? Yes No

Did these medications help your symptoms? (circle)									
1	2	3	4	5	6	7	8	9	10

No Relief *Completely Cured*