UROLOGY EXPERTS SYSTEM REVIEW

PATIENT NAME_____**DATE** _____/_____/**20**___

Do you currently or have you had any problems related to the following systems? Check YES or NO
Please explain any YES answers in the space provided

Constitutional Symptoms

Yes □ No □ Chills
Yes □ No □ Fever
Yes □ No □ Headache
Other_____

Eyes

Yes □ No □ Blurred Vision
Yes □ No □ Double Vision
Yes □ No □ Cataracts
Yes □ No □ Glaucoma
Yes □ No □ Pain
Other_____

Allergies/Immunologic

Yes □ No □ Hay Fever
Yes □ No □ Drug Allergies
Other_____

Neurological

Yes □ No □ Headaches
Yes □ No □ Black Outs
Yes □ No □ Seizures
Yes □ No □ Stroke
Yes □ No □ Tremor
Yes □ No □ Dizzy Spells
Yes □ No □ Numbness/Tingling
Yes □ No □ Depression
Other_____

Endocrine

Yes □ No □ Diabetes
Yes □ No □ Thyroid Trouble
Yes □ No □ Excessive Thirst
Yes □ No □ Too Hot/Cold
Yes □ No □ Tired/Sluggish
Other_____

Cardiovascular

Yes □ No □ Chest pain
Yes □ No □ Varicose Veins
Yes □ No □ High Blood Pressure
Yes □ No □ Irregular Heartbeat
Yes □ No □ Heart Attack
Yes □ No □ Heart Operations
Yes □ No □ Blood Vessel Problems

Abdomen

Yes □ No □ Pain
Yes □ No □ Ulcers
Yes □ No □ Gallbladder Trouble
Yes □ No □ Colitis
Yes □ No □ Blood in Stools
Yes □ No □ Diverticulitis
Yes □ No □ Jaundice
Yes □ No □ Liver Problems
Other_____

Respiratory

Yes □ No □ Wheezing or Cough

Integumentary

Yes □ No □ Skin Rash
Yes □ No □ Boils
Yes □ No □ Persistent Itch

Musculoskeletal

Yes □ No □ Joint Pain
Yes □ No □ Back Pain
Yes □ No □ Arthritis
Yes □ No □ Gout

Ear/Nose/Throat/Mouth

Yes □ No □ Sinus Problems
Yes □ No □ Hearing Problems
Yes □ No □ Ear Infection
Yes □ No □ Throat Problems

Genitourinary

Yes □ No □ Urinary Frequency
Yes □ No □ Prostate Surgery
Yes □ No □ Infection
Yes □ No □ Stones
Yes □ No □ Blood in Urine
Yes □ No □ Urine Leakage
Yes □ No □ Urine Retention
Yes □ No □ Painful Urination

Hematologic/Lymphatic

Yes □ No □ Anemia
Yes □ No □ Leukemia
Yes □ No □ Unusual Bruising
Yes □ No □ Swollen Glands
Yes □ No □ Blood Clotting

Physician: _____