# Urology Clinic Visit

**PATIENT NAME:** ____________________

**MR#:** ____________________

**DATE:** ____________________

What brings you to see the physician today?

Allergies:

Medications:

Hospitalization/Surgery:

| System Review | N | Y |
|---|---|---|
| Have you had fevers lately? | | |
| Have you lost weight lately? | | |
| Do you have headaches? | | |
| Do you have changes in vision? | | |
| Do you have black-out spells? | | |
| Do you have ringing in your ears? | | |
| Do you have bloody noses? | | |
| Do you have trouble swallowing? | | |
| Do you have chest pains? | | |
| Do you have shortness of breath? | | |
| Do you have irregular heart beats? | | |
| Do you wake up short of breath? | | |

*(Physician Use Only)*

CC:

**HPI:** *(Brief 1-3, **Extended >=4** (location, quality, severity, timing, duration, context, modifying factors, assoc signs and sx's)*

**ROS:** *(Problem Pertinent 1, Extended 2-9, Complete 10)*

| REVIEW OF SYSTEMS | | | | Positive Finding |
|---|---|---|---|---|
| + | Systems | - | Defer | |
| ☐ | Constitutional | ☐ | ☐ | |

| Family History (circl | |
|---|---|
| 1) | Both parents living/well |
| 2) | One parent deceased caused l |
| | |
| 3) | Both parents deceased causec |
| | a) Father |
| | b) Mother |
| | c) Siblings |
| | |

| Is there a family history of |
|---|
| "Heart Attacks" |
| Stroke |
| Diabetes |
| Urinary Stones |
| Kidney Problems |
| Prostate Cancer |
| Kidney Cancer |

(

Constitutional : T:

HEENT:

Chest: CVCV:

Abdomen:

GU:

Back:

Neuro:

Extremity:

| | | |
|---|---|---|
| Do you have nausea, vomiting, or diarrhea? | | |
| Do you have blood in your stool? | | |
| Do you have abdominal or flank pain? | | |
| Do you have difficulty voiding? | | |
| Do you have blood in your urine? | | |
| Do you have pain while voiding? | | |
| Do you have frequent urination? | | |
| Does your urine stream start and stop? | | |
| Do you have any problems with your joints? | | |
| Do you have seizures? | | |
| Do you have a skin rash? | | |

| Alcohol Consumption | Tobacco Consumption | Recreational Drugs |
|---|---|---|
| none | none | none |
| 1-3 drinks/wk | <1 pack/day | yes, type: |
| 4-6 drinks/wk | ~1 pack/day | |
| >6 drinks/wk | >=2 packs/day | |
| | quit | |

| ☐ | | ☐ | ☐ | |
|---|---|---|---|---|
| ☐ | Head & Face | ☐ | ☐ | |
| ☐ | Eyes | ☐ | ☐ | |
| ☐ | ENT | ☐ | ☐ | |
| ☐ | Neck | ☐ | ☐ | |
| ☐ | Cardiovascular | ☐ | ☐ | |
| ☐ | Chest (Breasts) | ☐ | ☐ | |
| ☐ | Gastrointestinal | ☐ | ☐ | |
| ☐ | Genitourinary | ☐ | ☐ | |
| ☐ | Lymphatic | ☐ | ☐ | |
| ☐ | Musculoskeletal | ☐ | ☐ | |
| ☐ | Extremities | ☐ | ☐ | |
| ☐ | Skin | ☐ | ☐ | |
| ☐ | Neuro/Psych | ☐ | ☐ | |

**Physician Signature:** ____________________

**Date:** ____________________

Diagnostic Studies:

U/A: Normal ________

Chem-7 ________

Radiology Studies: ________

Records Requested: ________

GU/Medical Dx:

1)

2)

3)

________ Schedule Surgery

________ Radiology

________ Laboratory

**MEDICARE ONLY**

☐ GC - Supervision of Res

☐ No Modifier - Teaching

☐ GE - Primary Care Exce

# Urology Clinic Visit

**y History (circle)**

eased caused by

ceased caused by

**mily history of (circle):**

Y N
Y N
Y N
Y N
Y N
Y N
Y N

**(Physician Use Only)**

**PFSH** *(Pertinent 1, Complete 2 Est Patients, 3 New Patients & Consults)*

## Physical Examination

***(Problem Focused 1, Expanded Problem Focus 6, Detailed 12, Comprehensive 18)***

P ________ BP ________ HT ________ WT ________

Pulmn: ________

U/A Abnormal (see attached report)

CBC/P PSA

Records Reviewed:

Plan:

Residents Signature:

ervision of Resident

fier - Teaching Physician Only

Physician Signature:

nary Care Exception Clinic