Urology Specialists of East Tennessee

Covenant Medical Group

Name: _____

Birth Date: _____

Today's Date: _____

Drug Allergies: _____

No Known Drug Allergies: _____

Current Medications:

Pharmacy Name: _____

Pharmacy Address: _____

Medication:	Dose:
_____	_____
_____	_____
_____	_____
_____	_____

Please check all that apply to you:

_____ Diabetes
_____ High blood pressure
_____ Arthritis
_____ Lung Disease
_____ Tuberculosis
_____ HIV
_____ Coronary Artery Disease
_____ Heart Attack When? _____
_____ Angina (chest pain)
_____ Childhood urology problems
_____ Urinary tract infections
_____ Prostate problems
_____ Bladder problems
_____ Kidney problems
_____ Kidney stones
_____ Hepatitis A? B? C?
_____ Spine problems
_____ Stroke When? _____

Previous surgery and year surgery was performed:

_____

_____

_____

Family History:

_____ Prostate cancer
_____ Prostate disease
_____ Bladder cancer
_____ Kidney cancer
_____ Kidney stones
_____ Mother's age at death
_____ Father's age at death

Physician Signature _____

REVIEW OF SYSTEMS

PATIENT NAME:_____ DATE OF BIRTH:_____

General:

	Yes	No
Weight Change > 10lbs		
Fever		
Fatigue		
Difficulty Sleeping		

Male:

	Yes	No
Sexual dysfunction		
Infertility		
Painful intercourse		

Head and Neck:

	Yes	No
Visual Changes (Not Glasses)		
Dizziness		
Sinus problems		
Frequent persistent nosebleeds		
Ear pain		
Trouble hearing		
Ringin In Ears		
Hoarseness		
Persistent sore throat		
Mouth sores		
Swollen glands (Frequent)		

Women:

	Yes	No
Breast pain/lumps		
Pelvic pain		
Vaginal discharge		
Vaginal dryness		
Frequent sweats/hot flashes		
Mentstrual problems		
Menopause		
Pregnancy Problems		

Respiratory/Lungs:

	Yes	No
Stop breathing during sleep		
Shortness of Breath		
Coughing up blood		
Wheezing		
Cough		
Sore Throat		
Snoring		

Skelotal:

	Yes	No
Gout		
Back Pain (Major)		
Neck Pain (Major)		
Weakness of arm or leg		
Joints Swelling/Stiffness		
Deformities of Back/Extremeties		

Heart/Vascular:

	Yes	No
Chest pain/tightness		
Smothering feeling at night		
Ankle swelling		
Palpitations		
Passing out		

Neuro:

	Yes	No
Numbness or tingling		
Severe frequent headaches		
Abnormal coordination		
Trouble with speech		
Forgetfulness/confusion		

Stomach/Bowel:

	Yes	No
Black/Bloody stools		
Nausea/Vomiting (Frequent)		
Frequent heart burn/acid (GERD)		
Abdominal pain		
Diarrhea (Frequent)		
Constipation		
Difficulty swallowing		

Skin and Hair Problems:

	Yes	No
Changes in hair/hair loss		
Major skin problems		
Wounds that will not heal		
Persistent rash		
Changes in moles		

Kidney/Bladder:

	Yes	No
UTI		
Urinary Incontinence		
Urinary Hesitancy		
Frequent Urination		
Urinary Urgency		
Urinating at night		
Pain with urination		
Blood in urine		
Urinary Retention		

Psych/Social:

	Yes	No
Anxiety		
Depression		
Insomnia		

_____

Signature (Patient or Legal Representative)

_____

Relationship to Patient *Date*

PATIENT NAME:_____ **DOB:**___/___/___

TO BE COMPLETED BY NURSE			
Weight		Height	
	lbs kgs		inches cm

PHQ-2 Depression Screening Questionnaire

How often have you been bothered by the below symptoms the last two weeks?

Feeling Down, Depressed, Hopeless	O Not at all O Several Days	O More than half the days O Nearly every day
Little interest - Pleasure in Activities	O Not at all O Several Days	O More than half the days O Nearly every day

PHQ-9 Detailed Depression Screening Questionnaire

If you selected "Not at all" for both questions above, please ignore this section.

Trouble Falling or Staying Asleep	O Not at all O Several Days	O More than half the days O Nearly every day
Feeling Tired or Little Energy	O Not at all O Several Days	O More than half the days O Nearly every day
Poor Appetite or Overeating	O Not at all O Several Days	O More than half the days O Nearly every day
Feeling Bad About Yourself	O Not at all O Several Days	O More than half the days O Nearly every day
Trouble Concentrating	O Not at all O Several Days	O More than half the days O Nearly every day
Moving or Speaking Slowly	O Not at all O Several Days	O More than half the days O Nearly every day
Thoughts Better Off Dead or Hurting Self	O Not at all O Several Days	O More than half the days O Nearly every day

Medication Adherence

Does the patient have any barriers to medication adherence?
(ie. Any reason that the patient cannot take medication as prescribed?)

O YES O NO

If YES, the reason is?
- O Financial
- O Transportation
- O Trouble Remembering
- O Health literacy
- O Lack of Confidence
- O Time Constraints
- O Cognitive deficit
- O Functional status impairment
- O Other

Is the patient taking over-the-counter medications?

O YES O NO

Fall Risk Assessment

1. Have you fallen in the last year? O YES O NO
2. Are you worried you might fall? O YES O NO
3. Do you use a cane or walker? O YES O NO
4. Do you need someone to help you get up in the morning? O YES O NO

Tobacco Use:

- ☐ Never (less than 100 in lifetime)
- ☐ 4 or less cigarettes (less than 1/4 pack)/day in the last 30 days
- ☐ 5-9 cigarettes (between 1/4 to 1/2 pack)/day in the last 30 days
- ☐ 10 or more cigarettes (1/2 pack or more)/day in the last 30 days
- ☐ Cigars or pipes daily within the last 30 days
- ☐ Cigars or pipes, but not daily within the last 30 days
- ☐ Smokeless tobacco user within last 30 days
- ☐ Smoker, current status unknown
- ☐ Former smokeless tobacco user, quit
- ☐ Former smoker quit more than 30 days
- ☐ Refused tobacco status screen
- ☐ Unable to assess due to cognitive impairment

Types:
- ☐ Cigarettes
- ☐ Cigars
- ☐ Oral
- ☐ Pipe
- ☐ Smokeless Cigarettes
- ☐ Spit Tobacco
- ☐ SNUS Products
- ☐ Other: _____

Packs Per Day ☐

Years Smoked ☐

Alcohol:

Use:
- ☐ Never used
- ☐ Deny use
- ☐ Past User
- ☐ Not used since pregnant
- ☐ Used early in pregnancy
- ☐ Unable to assess due to cognitive impairment
- ☐ Current user

Type:
- ☐ Beer
- ☐ Wine
- ☐ Liquor
- ☐ Other:_____

Frequency:
- ☐ 1-2 times per year
- ☐ 1-2 times per month
- ☐ 1-2 times per week
- ☐ 3-5 times per week
- ☐ Daily
- ☐ Several times per day
- ☐ Binge
- ☐ Occasional use
- ☐ Regular use

Advanced Directive

- O Yes
- O No
- O No Advanced Directive, information given
- O Unable to answer at this time
- O Healthcare Proxy
- O Revocation

Patient Preferred Pharmacy

Pharmacy Name

Phone