

ADULT PEDIATRIC UROLOGY

Review of Symptoms

Do you or have you had any problems related to the following symptoms? Circle Yes or No.
Please explain any Yes answers in space provided.

Current Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other	_____	

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other	_____	

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other	_____	

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other	_____	

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N
Other	_____	

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other	_____	

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/tingling	Y	N
Other	_____	

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other	_____	

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other	_____	

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other	_____	

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other	_____	

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other	_____	

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other	_____	

Psychologic

Are you generally satisfied with your life? _____
Do you feel severely depressed? _____
Have you considered suicide? _____
Other _____

Physician: _____

Date: _____