MOUNTAINSTAR
Ogden Specialty Clinic
affiliated with Ogden Regional Medical Center

PATIENT INFORMATION FOR UROLOGY - MALE

Name: _____ Date of Birth: _____

Date: _____ Primary Care Physician: _____

Social Security #: _____ ☐ Working Work #: ( ) _____

Occupation: _____ ☐Retired

Whom to Notify in an emergency: _____ Relationship to patient: _____

Emergency contact's phone #'s:

Home: ( ) _____

Work: ( ) _____

Cell: ( ) _____

Name of the physician who referred you: _____

What is the reason for your visit today?

_____

Are you currently experiencing any of the following symptoms?

- ☐ Excessive daytime frequency
- ☐ Urgency to void / urinate
- ☐ Burning / pain with urination
- ☐ Getting up at night to void
  How many times: _____
- ☐ Straining to urinate
- ☐ Interrupted stream
- ☐ Sense of incomplete emptying
- ☐ Blood in urine
- ☐ Urinary tract infections (UTI)

- [ ] Excessive dribbling
- [ ] Urinary incontinence
- [ ] Kidney stones
- [ ] Erectile dysfunction

When was your most recent PSA? _____

Do you take any medications, including aspirin? (Medication/Dose)

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any medications? [ ] Yes [ ] No

If yes, which medications?

_____

Latex sensitivity? [ ] Yes [ ] No