

The OAB Clinic

Name:		Referring MD:		Date:	
DOB:		Level of Education:		Occupation	
Marital Status:				Ht:	Wt
Allergies:					

Please describe your problem:	
Location?	When did you first notice it?
Associated Symptoms?	
Does anything improve it?	Make it worse?
Communication Issues:	Do you have an Advanced Directive?
Language Spoken:	

EMAIL ADDRESS:

Circle any Medical Problems that apply:			Please list all surgeries	Year
Heart Disease	High Blood Pressure	List any o		
Pacemaker/Defibrillator	Stroke/Seizure			
Lung Disease	Kidney Problems			
Diabetes	Bleeding Problems			
Bowel Problems				

Medication	Dose	Frequency	Medication	Dose	Frequency

Have you ever or do you use the following?				Occupation?	
Tobacco?	Alcohol?	Drugs?			

Family History of diseases				

Please check if you have ever had any of the following symptoms:

General	ENT	Respiratory	Neurologic	Genitourinary	
<input type="checkbox"/> Fever	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Short of breath	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Painful urination	
<input type="checkbox"/> Chills	<input type="checkbox"/> Dentures	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Numbness/tingle	<input type="checkbox"/> Frequent or urgent urination	
<input type="checkbox"/> Headaches	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Difficult balance	<input type="checkbox"/> Urine leakage	
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Tuberculosis	List Other:	<input type="checkbox"/> Urinary tract infections	
List other:	List other:	List other:		<input type="checkbox"/> Blood in Urine	
			Psychological	<input type="checkbox"/> Kidney problems	
Eyes	Cardiovascular	Gastrointestinal	Psychological	For Men	For Women
<input type="checkbox"/> Double vision	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Depression	<input type="checkbox"/> Erection problems	# pregnancies
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Constipation	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Testicular lump	
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Blood pressure	<input type="checkbox"/> Diarrhea	List Other:	<input type="checkbox"/> Prostate procedure	# vaginal deliveries
List other:	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Rectal bleeding	Hematologic	<input type="checkbox"/> Elevated PSA	
	<input type="checkbox"/> Ankle swelling	<input type="checkbox"/> Use Antacids	<input type="checkbox"/> Clotting Disease	List other:	Difficult deliveries?

