ASHOK J. KAR, M.D., INC.
ADULT UROLOGY & MALE INFERTILITY

Name _____ Age _____ Date _____

Height _____ Weight _____ Date of Birth _____

Chief Complaint

What is the main reason for your visit today? (Describe the problem in detail)

_____

_____

_____

History of Present illness

Please circle the appropriate response

Do you get up at night to urine?	❑ Yes ❑ No	If yes how often _____
Does your urine come out freely?	❑ Yes ❑ No	
Do you have to strain to urine?	❑ Yes ❑ No	
When you get the urge to urinate, can you hold it?	❑ Yes ❑ No	
Do you have burning with urination?	❑ Yes ❑ No	
Have you noticed blood in your urine?	❑ Yes ❑ No	
Have you had a urinary tract infection?	❑ Yes ❑ No	
Have you had a kidney stone?	❑ Yes ❑ No	

Physician use only: (Comments/Notes)

_____

_____

_____

Past Medical History

Please circle the appropriate response

Do you have or have ever had:

Diabetes	❑ Yes ❑ No	If yes, do you take insulin? ❑ Yes ❑ No
High blood pressure	❑ Yes ❑ No	
Heart problems	❑ Yes ❑ No	
Any other medical problems	❑ Yes ❑ No	

If yes, please list them all: _____

_____

_____

List any surgeries you have had _____

Are you on any medications? ❑ Yes ❑ No

If yes, please list all of them: _____

_____

Do you have any allergies to any medications? ❑ Yes ❑ No If yes, please list _____

Do you take Aspirin or any other blood thinners? ❑ Yes ❑ No

1310 W. STEWART DRIVE, # 402 ORANGE, CA 92868 TEL: (714)628-1341 FAX: (714)628-1345

ASHOK J. KAR, M.D., INC.
ADULT UROLOGY & MALE INFERTILITY

Do you have a **Family History** of?
(Example: MOTHER, FATHER, SISTER, BROTHER Etc)

		If yes, in whom?
Diabetes	❑ Yes ❑ No	_____
High blood pressure	❑ Yes ❑ No	_____
Heart disease	❑ Yes ❑ No	_____
Cancer	❑ Yes ❑ No	_____

Social History:

Married	❑ Yes ❑ No	Children	❑ Yes ❑ No
Do you currently smoke?	❑ Yes ❑ No	If yes, how much?	_____
Have you smoked in the past?	❑ Yes ❑ No	Stopped when?	_____
Do you drink alcohol?	❑ Yes ❑ No	If yes, how much?	_____
What type of work do you do?	❑ Yes ❑ No		

If not currently working, what type of work did you do in the past? _____

Review of systems:

Do you now or have ever had any problems related to the following systems? Tick Yes or No

Constitutional Symptoms

Fever	❑ Yes ❑ No
Chills	❑ Yes ❑ No
Other	_____

Integumentary

Skin rash	❑ Yes ❑ No
Peristent itch	❑ Yes ❑ No
Other	_____

Eyes

Blurred vision	❑ Yes ❑ No
Double vision	❑ Yes ❑ No
Other	_____

Ear/Nose/Throat/Mouth

Hearing lost	❑ Yes ❑ No
Sinus problems	❑ Yes ❑ No
Other	_____

Neurological

Seizures	❑ Yes ❑ No
Strokes	❑ Yes ❑ No
Other	_____

Endocrine

Excessive thirst	❑ Yes ❑ No
Too hot/cold	❑ Yes ❑ No
Other	_____

Cardiovascular

Chest pain	❑ Yes ❑ No
Palpitations	❑ Yes ❑ No
Varicose veins	❑ Yes ❑ No
Other	_____

Respiratory

Shortness of breath	❑ Yes ❑ No
Wheezing	❑ Yes ❑ No
Frequent cough	❑ Yes ❑ No
Other	_____

Gastrointestinal

Constipation	❑ Yes ❑ No
Diarrhea	❑ Yes ❑ No
Ulcer/reflux disease	❑ Yes ❑ No
Other	_____

Hematologic

Easy bruising	❑ Yes ❑ No
Blood clotting problems	❑ Yes ❑ No
Other	_____

Physician use only

Post Void residual : Catheter Ultrasound
Radiologic studies :
Impression:
Plan

Letter to _____ faxed on _____ Sig _____

1310 W. STEWART DRIVE, # 402 ORANGE, CA 92868 TEL: (714)628-1341 FAX: (714)628-1345