erlanger

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