

Southeast Texas Urology Associates, L.L.P.

Date: _____

FOLLOW-UP VISIT

NAME _____

Reason for today's visit: _____

How long have you had these symptoms?: _____

Primary Care Doctor: _____

Referring Doctor: _____

Symptoms: **Please Circle Yes or No to Each Symptom**

- | | | |
|------------------------------|------------------------------------|----------------------|
| Y/N Fever | Y/N Urethral Discharge | Y/N Blind |
| Y/N Chills | Y/N Blood in Urine | Y/N Hearing Loss |
| Y/N Weight Loss | Y/N Leaking of Urine | Y/N Nasal Stuffiness |
| Y/N Weight Gain | Y/N Urgency to Void | Y/N Dry Mouth |
| Y/N Night Sweats | Y/N Voiding at Night | Y/N Sore Throat |
| Y/N Malaise (feeling poorly) | Y/N Slow Stream | Y/N Rash |
| Y/N Abdominal Pain | Y/N Difficulty Starting Stream | Y/N Dry Skin |
| Y/N Constipation | Y/N Incomplete Emptying of Bladder | Y/N Bruising |
| Y/N Diarrhea | Y/N Masses Protruding from Vagina | Y/N Lesions/Ulcers |
| Y/N Nausea | Y/N Straining to Urinate | Y/N Dizziness |
| Y/N Vomiting | Y/N Burning with Urination | Y/N Forgetfulness |
| Y/N Swelling of Legs | Y/N Loss of Sexual Interest | Y/N Migraines |
| Y/N Chest Pain | Y/N Painful Intercourse | Y/N Loss of Balance |
| Y/N Irregular Heartbeat | Y/N Back Pain/Surgery | Y/N Depression |
| Y/N Vaginal Bleeding | Y/N Sore Muscles | Y/N Swollen Glands |
| Y/N Kidney (flank) Pain | Y/N Arthritis | Y/N Bleeds Easily |
| Y/N Shortness of Breath | Y/N Hepatitis | Y/N Blood Clots |
| Y/N Pelvic Pain | Y/N Reflux | Y/N Wheezing |
| Y/N Vaginal Discharge | Y/N Glaucoma | Y/N Cough |
| Y/N Vaginal Delivery | Y/N Blurry Vision | Y/N Joint Problems |
| If yes, how many _____ | Y/N Cataracts | |