

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 Burning Upon Urination	Y/N Urgency to Urinate	Y/N Weight Loss
Y/N Discharge from Penis	Y/N Weak Stream	Y/N Weight Gain
Y/N Blood in Urine	Y/N Straining to Urinate	Y/N Loss of Sexual Interest
Y/N Blood in Semen	Y/N Foul Smelling Urine	Y/N Loss of Erection
Y/N Leaking of Urine (incontinence)	Y/N Lesions on Penis	Y/N Curvature of Erection
Y/N Pelvic Pain	Y/N Air Coming Out of Penis	Y/N Double Vision
Y/N Back Pain	Y/N Urination at Night	Y/N Blurry Vision
Y/N Sore Muscles	Y/N Constipation	Y/N Cataracts
Y/N Arthritis	Y/N Diarrhea	Y/N Glaucoma
Y/N Joint Problems	Y/N Nausea	Y/N Blind
Y/N Kidney Pain	Y/N Vomiting	Y/N Skin Rash
Y/N Abdominal Pain	Y/N Reflux	Y/N Dry Skin
Y/N Incomplete Emptying of Bladder	Y/N Fever	Y/N Bruising
Y/N Frequency of Urination	Y/N Chills	Y/N Lesions/Ulcers
Y/N Difficulty Starting Urine Flow	Y/N Night Sweats	Y/N Shortness of Breath
Y/N Joint Problems	Y/N Hearing Loss	Y/N Wheezing
Y/N Varicose Veins	Y/N Nasal Stuffiness	Y/N Cough
Y/N Hepatitis	Y/N Dry Mouth	Y/N Chest Pain
Y/N Swelling of Legs	Y/N Sore Throat	Y/N Swollen Glands
Y/N Dizziness	Y/N Forgetfulness	Y/N Bleeds Easily
Y/N Migraines	Y/N Loss of Balance	Y/N Blood Clots
Y/N Depression	Y/N Irregular Heartbeat	Y/N Change in Bowels