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Bladder Cancer
Genitourinary Oncology

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**New Patient History
Bladder**

Name: _____

DOB: _____

Referred by: _____

Phone: _____

Date of Onset: _____

Initial symptom/reason for visit:

Previous Surgery or Cystoscopy:

Previous Treatments:

Recent X-ray Studies:

Previous Bladder Tumors: Yes No

If Yes:

Dates: _____ Grade/Stage: _____ Rx: _____

Do you have:

Visible blood in the urine? N Y

Burning with urination? N Y

Other related pain? N Y

Frequency of urination? N Y

Urination at night? N Y

Decrease force of stream? N Y

Leakage of urine? N Y

History of kidney stones? N Y

Do you have clots? N Y

Describe: _____

How many times a day? _____

How many times a night? _____

Do you use Pads? N Y

Number Per Day _____

Dates: _____ Side(s): _____

Other related problems?

Exposure to Cancer Causing Agents (Carcinogens)

Tobacco:

Never Yes Quit Date: _____

Maximum number of cigarettes/ day: _____

Pipe: N Y Cigars: N Y Chew/Snuff: N Y

Family History of Cancer? Bladder, Kidney, or Prostate Disease?

Past Medical History

Describe Your General Health:

Illnesses:

Asthma Diabetes Heart Disease

Kidney Disease Pneumonia TB

Other: _____

Allergies:

Medicines/Dose:

Immunizations:

Past Surgical History: (Please List Procedures and Dates)

Systems Review: (please circle if present)

Normal Weight: _____ Height: _____ Constitutional: fever chills
 Eyes: Lenses Blurring Double Spots
 Ears: Ringing Decreased Hearing
 Nose/Throat: Sinuses Swallowing
 Cardiovascular: Shortness of Breath Chest Pain Ankle Swelling Calf Pain Irregular Heart Beat
 I can climb ___ flights of stairs without stopping.
 Respiratory: Cough Blood in Sputum Wheezing
 Gastrointestinal: Nausea Vomiting Constipation Diarrhea Blood in Stool Belly Pain Heartburn
 Genitourinary: Discharge Bleeding Sexual Problems
 Musculoskeletal: Pain or Stiffness in Bones or Joints Muscle Pain or Weakness
 Psychiatric: Depression Memory Loss Personality Change
 Neurologic: Numbness Tingling Shooting Pains Weakness Seizures Loss of Consciousness
 Dermatologic: Rash Itching Growths/Changes in Moles
 Endocrine: Heat or Cold Intolerance Increased Thirst Lack of Energy Slow Healing
 Hematologic/Lymphatic: Increased Bruising Bleeding Node Swelling
 Allergic/Immunologic: Rashes Allergies Itching; Hives
 Family History of: Diabetes Heart Kidney, Bladder or Prostate Disease Bleeding Disorders Cancer

Family History:	Living/Age	Deceased/Age	Illnesses
Father			
Mother			
Brother(s)			
Sister(s)			
Children			

Social History: (* optional)

Occupation: _____
 *Marital Status: _____
 *Activity: I exercise vigorously _____ times per week
 I sleep about _____ hours in 24
 *Diet: I eat _____ servings of vegetables or fruit per day.
 I have red meat _____ times per week; fish _____ times per week
 I have salad _____ times per week
 I eat fast food __+_ and restaurant food _____ times per week.
 My favorite food is: _____
 Alcohol: N Y _____ drinks per week
 Tobacco: N Y
 *Hobbies: _____
 *Recent Foreign Travel: _____
 *Religious Preference: _____