

*******MD Use ONLY*******
----PSA Exam Form -MALE----

Patient Name: _____ (Place Sticker Here)

 DOS: _____ PSA#: _____

***** History of Patient's Present Illness ***** To Be Completed by MD/APRN *****

DESCRIPTION of discomfort/symptoms (Where, how severe, when, how often):

ONSET/LENGTH OF experienced symptoms:

ALLEVIATING/PRECIPIATING Factors &/or Other RELATED S/S:

PREVIOUS TREATMENTS, TESTING, OR MEDICATIONS:

_____ W/D, W/N Male _____ See Dictation _____
 • • • Height: _____ Weight: _____ T _____ P _____ RR _____ BP _____ / _____

_____ WNL* • Orientation-----See Dictation _____
 _____ WNL* • Mood/Affect-----See Dictation _____
 _____ WNL* • Skin-----See Dictation _____
 _____ WNL* • Thyroid-----See Dictation _____
 _____ WNL* • Chest (auscult)----- See Dictation _____
 _____ WNL* • Breast/Chest-----See Dictation _____
 _____ WNL* • Cardiac (auscult)-----See Dictation _____
 _____ WNL* • Lymph (axilla/groin)-----See Dictation _____
 _____ WNL* LE Reflexes-----See Dictation _____
 _____ WNL* Back-----Hypertrichosis _____ Cleft _____ Other _____
 _____ WNL* • Abdomen----- See Dictation _____
 _____ WNL* • Hernia----- See Dictation _____
 _____ WNL* • Liver/Spleen-----See Dictation _____
 _____ WNL* • Stool/Guaiac-----See Dictation _____

Male GU System	Tanner:	1	1-2	2-3	3	3-4	4	4-5	5
Penis-----									
_____ WNL* (circ'd) <input type="checkbox"/> See Dictation _____									
_____ WNL (uncirc'd) _____									
Meatus-----									
_____ WNL <input type="checkbox"/> See Dictation _____									
Scrotum-----									
_____ Left -WNL _____ Right -WNL <input type="checkbox"/> See Dictation _____									
Testes-----									
_____ Left -WNL _____ Right -WNL <input type="checkbox"/> See Dictation _____									
Epididymides-----									
_____ Left -WNL _____ Right -WNL <input type="checkbox"/> See Dictation _____									
Anus/Perineum-----									
_____ WNL _____ See Dictation _____ Not Indic. ----Sem. Vesicles _____ See Dictation _____									
_____ WNL---Anal Tone _____ See Dictation _____ Not Indic. ----Prostate _____ See Dictation _____									

Data Reviewed? Radiology? _____
 Personal Review of Scans/Image? _____
 Clinical Labs _____

Billing based on TIME?
 Total Visit Time: _____
 Time spent in Counseling & Coord. Of Care: _____

MD Initial & Date

Surgery? Yes No

Pediatric Surgical Associates

Patient Intake Form

Pediatric Urology

Patient Name: _____ (Place Sticker Here)

DOS: _____ PSA#: _____

Patient Name: _____

DOB: _____

Date of Visit: _____

Reason for Visit today?

Review of Systems (Are you currently experiencing...):

Urologic Problems:

Bladder/kidney/UTI's.....NO.....YES

Pain when urinating.....NO.....YES

Toilet trained.....NO.....YES

Fever with infections.....NO.....YES

Blood in urine.....NO.....YES

Leak urine during the dayNO.....YES--- how often _____

Get up to urinate at night.....NO.....YES--- how often _____

Wet the bed.....NO.....YES--- how often _____

When your child needs to urinate, is it sudden.....NO.....YES

How many times per day does your child urinate _____

How often does your child stool _____

Stools difficult or painful to pass.....NO.....YES

Constitutional Problems (Fever, chills, etc...)

YES NO _____

Pulmonary (Breathing) Problems (Wheezing, coughing, etc...):

YES NO _____

Cardiac (Heart) Problems (Turning Blue, Irregular Heartbeat, etc...):

YES NO _____

Skin Problems (Rashes, itching, redness, etc....)

YES NO _____

Muscle/Joint Problems (Back, leg Pain, etc...):

YES NO _____

ENT (Ears, Nose, Throat) Problems (Ear Infections, congestion, etc...):

YES NO _____

GI (Gastrointestinal) Problems (Constipation, Diarrhea, Nausea/Vomiting, etc..)

YES NO _____

Eye Problems (Glasses, pain, etc...)

YES NO _____

Neurologic Problems (Learning Problems, dizziness, etc...)

YES NO _____

Endocrine (Gland) Problems (Excessive Thirst, too hot/cold, etc...):

YES NO _____

Psychiatric Problems (Depression, Anxiety, etc...):

YES NO _____

Allergies to (Seasonal, Dietary, etc.): _____

What is the Reaction? _____

Heme(Blood)/Lymph Problems (Blood Transfusions, Clotting Problems, Swollen Glands, Bruising, etc...):

YES NO _____

Past Medical History (Please circle all that apply):

Eyes:	Glaucoma	
Neurologic	Seizures	ADD/Hyperactivity
Endocrine (Gland)	Diabetes	Adrenal Disease
Pulmonary (Breathing)	Asthma/Wheezing	Pneumonia
Cardiac (Heart)	High Blood Pressure	Congenital Heart Disease
Gastrointestinal	Crohn's/UC	GE Reflux
Infections	Hepatitis	Tuberculosis (Tb)

Other _____

Syndromes/Chromosomal/Other Problems: _____

Has child had any surgeries: _____

Problems (for child) during Pregnancy _____

Baby Born at: _____ weeks (40 is normal) Birth Weight? _____ Problems at birth? _____

Family Medical History:

Problems (for mother) during pregnancy: _____

Drugs/medications taken during pregnancy: _____

Related diseases: _____

Abnormal reactions to anesthesia _____

Bleeding disorders _____

Social History:

Child lives: **At Home** **In a Foster Home** **In a Facility** _____

Child lives with: **Mother** **Father** **Guardian/Relative** **Other** Any Siblings? NO / YES—How Many? _____

Activities/Interests _____

Alcohol/Tobacco/Drugs Yes No

Recent Travel _____

MD Comments:

MD Initial & Date signifying Review of ROS & PFSH _____