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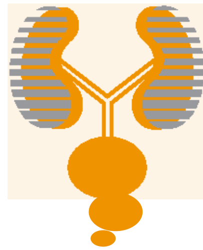

MEDICAL HISTORY FORM

[Account # __________________ Office Use Only]

Name: ____ Date: ________________________________

Referring Doctor: ___________________________ Primary Care Doctor: _______________________________

HISTORY OF PRESENT ILLNESS

Why are you seeing the doctor today? ____

How long have you had this problem? ____

Are there any symptoms that go along with the problem/pain? ____

____

Is the problem/pain continuous or does it come and go? ____

Have you tried any medicine/treatment for this problem/pain? ____

What improves or worsens the problem/pain? ____

Additional comments about your problem: ____

____

CURRENT URINARY PATTERN

How many times a night do you urinate after you fall asleep? ____

How often do you urinate during the day? ____

Do you have pain with urination? ____

Have you seen blood in your urine? ____

Have you had blood in your urine on microscopic examination? ____

Does the urinary flow have a good pressure? ____*

Are you able to empty your bladder fully? ____*

When you get the urge to urinate, do you have trouble getting to the bathroom on in time? ___________________________

Do you ever lose control of the urine (incontinence)? How often? Under what circumstances? _______________________

Do you strain to start urination? ____

Does it take a long time for the urinary stream to start when you get to the bathroom? _____________________________

Have you had kidney stones? _____ Please provide dates of attacks that did not require surgery: ____________________

Did you ever require a surgical procedure for stones? _______

State type of procedure and date performed: ____

Have you ever had urinary infections such as kidney or bladder infections? State how many times and date of infections:

____

Have you ever had any type of urologic surgery? _______ What type of surgery? __________________________________

Date of surgery: _________________

Name: ____ Date: ____________________________

PAST MEDICAL HISTORY

CURRENT MEDICATIONS – **Please list ALL medications you are currently taking including over the counter meds**

Drug Name:	Strength:	Directions/How, you take it:
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____

Attach list if necessary.

PHARMACY NAME: ____________________________________**Phone # and/or address:** __________________________________

MEDICATION ALLERGIES ______________________________________**OTHER ALLERGIES**________________

PAST MEDICAL HISTORY: **Please CHECK if you have ever had any of the following diseases or conditions:**

☐ADD
☐ADHD
☐Alcoholism
☐Allergies
☐Alzheimer's Disease
☐Anemia
☐Aneurysm
☐Angina
☐Anorexia
☐Anxiety disorder
☐Arthritis
☐Arrhythmia
☐Aortic aneurysm
☐Aortic stenosis
☐Aortic insufficiency
☐Asthma
☐Atrial fibrillation
☐Back pain
☐BPH
☐Bi-polar disorder
☐Bladder cancer
☐Bleeding disorder
☐Blindness
☐Brain tumors
☐Breast cancer
☐Bronchitis
☐Cataracts
☐Cerebrovascular
☐Cholecystitis
☐Cholelithiasis
☐Chronic fatigue syndrome
☐Chronic liver disease
☐Chronic lung disease
☐Chronic renal insufficiency
☐Chronic renal failure
☐Colitis
☐Constipation
☐Colon cancer
☐Colon condition
☐Congenital heart disease
☐Congenital heart failure
☐Crohn's Disease
☐Deafness
☐Deep vein thrombosis
☐Depression
☐Diabetes-non ins dependent
☐Diabetes-insulin dependent
☐Diabetes-uncontrolled
☐Diarrhea
☐Eating disorder
☐Ear Infections
☐Elevated PSA
☐Emphysema
☐Enlarged heart
☐Epilepsy
☐Fibrocystic breast disease
☐Fibromyalgia
☐Gastric cancer
☐Gastritis
☐Gastroenteritis
☐Gastric cancer
☐GERD
☐Glaucoma
☐Goiter
☐Gout
☐Hay fever
☐Heart attack
☐Heart disease
☐Heart valve problem
☐Heart murmur
☐Hemorrhoids
☐Hepatitis
☐Herniated disc
☐Hiatal hernia
☐High cholesterol
☐High blood pressure
☐Impaired glucose tol.
☐Infertility
☐Irritable bowel disease
☐Inflam. bowel disease
☐Kidney disease
☐Kidney infections
☐Kidney stones
☐Infectious disease
☐Laryngeal cancer
☐Leukemia
☐Liver disease
☐Lung disease
☐Lung cancer
☐Lymphoma
☐Malaise
☐Melanoma
☐Mental illness
☐Migraine
☐Mitral stenosis
☐Mitral insufficiency
☐Mitral valve prolapse
☐Mumps
☐Nervous breakdown
☐Obesity
☐Osteoporosis
☐Pancreatitis
☐Pancreatic cancer
☐Peptic ulcer
☐Phlebitis
☐Polio
☐Prostate cancer
☐Prostatitis
☐Pulmonary embolism
☐Rectal fissure
☐Rectal cancer
☐Rheumatic Fever
☐Sexually trans. disease
☐Sickle cell anemia
☐Stroke
☐Suicide attempt
☐Testicular cancer
☐Thyroid disease
☐Tuberculosis

Name: ____ Date: ____________________________

Other medical history: ____

____

SURGICAL HISTORY

Please CHECK if you have had any of the following surgeries. Write the date of surgery:

☐Amputation
☐Angioplasty
☐Aortic Aneurysm Repair
☐Appendectomy
☐Arthroscopic Surgery
☐Back Surgery
☐Bariatric Surgery
☐Bladder Surgery
☐Bowel Resection
☐Brachytherapy
☐Brain Surgery
☐Breast Surgery
☐Biopsy of Prostate
☐CABG
☐Carotid Artery Surgery
☐Carpal Tunnel Surgery
☐Cataract Surgery
☐Cervical Spine Surgery
☐Cholecystectomy
☐Circumcision
☐Colon Resection
☐Colonoscopy
☐Corneal Surgery
☐Cystoscopy
☐Cystoscopy and fulguration
☐Cyst Removal
☐Deliveries (Vaginal or C-Section)
☐Ear Surgery ☐R or ☐L
☐EGD
☐Epididymectomy
☐ESWL ☐R or ☐L

☐Eye Surgery ☐R or ☐L
☐Facial Surgery
☐Foot Surgery ☐R or ☐L
☐Gastric Surgery
☐Hand Surgery ☐R or ☐L
☐Heart Surgery
☐Heart Transplant
☐Hemorrhoidectomy
☐Herniorrhaphy☐R or ☐L
☐Hip Surgery ☐R or ☐L
☐Hydrocelectomy ☐R or ☐L
☐Ileal conduit
☐Ileostomy
☐Indigo Laser Surgery
☐Inguinal Herniorrhaphy ☐R or ☐L
☐Knee Surgery ☐R or ☐L
☐Laminectomy
☐Laparoscopy
☐Laparotomy
☐Leg Surgery ☐R or ☐L
☐Liver Surgery
☐Lumpectomy
☐Lung Surgery
☐Lymphatic Node Dissection
☐Lysis Adhesions
☐Mastectomy
☐Mastoid Surgery
☐Meatotomy
☐Nasal Surgery
☐Needle Biopsy

☐Nephrectomy __☐R or ☐L
☐Nephrolithotomy ☐R or ☐L
☐Orchiectomy ☐R or ☐L
☐Pacemaker Insertion
☐Parathyroidectomy
☐Penile Implant
☐PEG
☐PE Tubes
☐Pilonidal Cyst Incision
☐Radical Prostatectomy
☐Renal Transplant
☐Rotator Cuff Surgery ☐R or ☐L
☐Septoplasty
☐Sinus Surgery
☐Skin Grafting
☐Spermatocelectomy ☐R or ☐L
☐Splenectomy
☐Stomach Surgery
☐Tonsil Surgery
☐Thyroid Surgery
☐TUMT Prostate
☐TUR Bladder tumor
☐TUR Prostate
☐Umbilical Hernia
☐Ureteroscopy ☐R or ☐L
☐Varicocelectomy ☐R or ☐L
☐Vasectomy
☐Vein Stripping
☐Ventral Hernia Repair
☐VLAP

Other: ____

____

Name: ____ Date: ______________________________

SEXUAL HISTORY (These questions, like all the others, are protected by medical confidentiality. If any questions make you uncomfortable, please omit.)

What is your sexual orientation (straight or gay or bisexual)? ____

Are you sexually active? ____

For men: Are you having any difficulties with your erections? Please describe: ______________________________

____

For women: Are you having any sexual difficulties? Please describe: ______________________________________

____

Please list an sexually transmitted diseases that you have had: ____

HIV STATUS: ☐ Negative: ☐ Positive: ☐ Not Known:

FAMILY HISTORY

Please CHECK and indicate which family member has/had any of the following: (Mother, Father or Siblings):

☐Arthritis	__________	☐Gout	_________	☐Multiple Sclerosis	_________
☐Bedwetting	__________	☐Heart Attack	_________	☐Laryngeal Cancer	_________
☐Bladder Cancer	__________	☐Hypertension	_________	☐Prostate Cancer	_________
☐Crohn's Disease	__________	☐Kidney Disease	________	☐Stroke	_________
☐Depression	__________	☐Kidney Stones	_________	☐Testis Cancer	_________
☐Diabetes	__________	☐Melanoma	_________	☐Tuberculosis	_________

Has any blood relative had cancer of the prostate, kidney, bladder or testicles? __________________

Whom? __________________________

Other Family History: ____:

SOCIAL HISTORY

Please provide the following information:

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Common Law Spouse

Dependants: Please indicate # of each, if you have:

______Sons ______Daughters ______Parents ☐ None

Occupation (if retired, indicate from what occupation): ____ **Retired** ☐ **Yes** ☐ **No**

Name: ____ Date: ______________________________

Exercise on a regular basis ☐ **Yes** ☐ **No**

Alcohol Consumption (check correct answer):

1. How often do you have a drink containing alcohol?

☐ Never (0 points)
☐ Monthly or less (1 points)
☐ Two to four times a month (2 points)
☐ Two to three times per week (3 points)
☐ Four or more times a week (4 points)

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1 or 2 (0 points)
☐ 3 or 4 (1 points)
☐ 5 or 6 (2 points)
☐ 7 to 9 (3 points)
☐ 10 or more (4 points)

3. How often do you have six or more drinks on one occasion?

☐ Never (0 points)
☐ Less than Monthly (1 points)
☐ Monthly (2 points)
☐ Two to three times per week (3 points)
☐ Four or more times a week (4 points)

Add the numerical value of each answer selected to get your total alcohol consumption score.

TOTAL SCORE: ___________

Tobacco per day:

☐ No ☐Yes Packs/day ______ Numbers of years you have smoked: ________

If you previously smoked, when did you stop? ___________ How many years did you smoke? ___________

How many packs a day at your maximum? ________

Recreational Drugs: ☐ None if yes, please list: ____

Caffeinated beverages: ☐ **No** ☐**Yes** **Type:** ______________ **How many a day?** ________

Recent Travel: ☐ None ☐ United States ☐ Worldwide Where:______________________________

Name: ____ Date: _________________________________

REVIEW OF SYSTEMS

Please CHECK if you have any of the following conditions:

CONSTITUTIONAL – Do you have ☐ fever ☐ chills or ☐ weight loss?

EYES – Do you have ☐ blurred vision ☐ pain in the eyes or ☐ double vision?

NEUROLOGICAL – Do you have ☐ tremors ☐ numbness/tingling or ☐ dizzy spells?

ENDOCRINE – Do you have ☐ excessive thirst ☐ feelings of hot or cold or ☐ tiredness?

GASTROINTESTINAL – Do you have ☐ nausea/vomiting ☐ constipation ☐ diarrhea ☐ abdominal pain or ☐ irregular bowel movements?

CARDIOVASCULAR – Have you ever had prolonged ☐ chest pain ☐ irregular heart beat or ☐ swelling of lower legs?

INTEGUMENTARY – Do you have a ☐ skin rash ☐ boils or ☐ persistent itch?

MUSCULOSKELETAL – Do you have ☐ arthritis ☐ bone or joint pain?

ENT – Do you have ☐ earaches ☐ sinus problems or ☐ sore throat?

RESPIRATORY – Do you have ☐ wheezing ☐ frequent coughing or ☐ shortness of breath ☐ asthma ☐ emphysema

HEMATOLOGIC/LYMPHATIC – Do you have ☐ swollen glands or ☐ blood clotting problems?

PSYCHOLOGIC – Do you have ☐ depression or ☐ excessive anxiety ☐ bipolar disorder ☐ schizophrenia

Name: ____ Date: ______________________________

OTHER

Is there anything else you would like to tell us about your health? ____

____

____

Comments: ____

____

____

____