MALE PATIENT HISTORY FORM

PATIENT'S NAME: _____ DATE OF BIRTH: _____ AGE: _____

PRIMARY CARE PHYSICIAN (FAMILY DOCTOR) _____

CHIEF COMPLAINT (What is the main reason for your visit to the urologist today? How long have you been having this problem? _____

HISTORY OF PRESENT ILLNESS

1-7	Mild
8-19	Moderate
20-35	Severe

Circle your score for each below

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
Over the last month, how many times did you most typically get up to urinate from the time you went to bed until the time you got up?	0 times	1 times	2 times	3 times	4 times	5 times

Do you have or have you recently had any of the following listed below? Please circle your responses.

Blood in your urine?	YES	NO
Burning or pain when you urinate?	YES	NO
Back pains?	YES	NO
Loss of urine when coughing, straining or sneezing?	YES	NO
Discharge from the penis?	YES	NO
Kidney or bladder stones?	YES	NO
Urinary tract infections?	YES	NO
Bedwetting or daytime wetting of clothes?	YES	NO
History of a sexually transmitted disease (herpes, gonorrhea, chlamydia, etc.)?	YES	NO
Pain with sexual intercourse?	YES	NO
Swollen or painful testicles?	YES	NO
Skin problems in the genital or groin area?	YES	NO
Fertility problems?	YES	NO
Problems getting or keeping erections?	YES	NO
Undescended testicles?	YES	NO
Have you ever had kidney x-rays (IVP or ultrasound) performed?	YES	NO

PAST MEDICAL AND SURGICAL HISTORY

Serious Medical Illnesses (Check all that apply)

____ Heart problems? ____ Thyroid problems ____ Cancer ____ Arthritis

____ Lung (breathing) problems ____ Kidney disease ____ Neurological problems ____ Bleeding problems

____ High blood pressure ____ Ulcers ____ Diabetes

Previous Major Surgeries (Please list)

Date	Type	Surgeon	Hospital

Other Surgeries or Previous Hospitalizations (Please list)

Date	Reason	Physician/Surgeon	Hospital

MEDICATIONS

Please list all prescription and over-the-counter medications, including vitamins and herbs that you are taking.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Do you use any nitroglycerin medications (medicine for chest pain?) ____ Yes ____ No

ALLERGIES TO MEDICATIONS

_____ _____

_____ _____

_____ NKDA

Have you had a reaction to iodine x-ray dye? ___ Yes ___No

If yes, what type of reaction? _____

Are you allergic to shellfish? ___Yes ___ No

SOCIAL HISTORY

_____ Married _____ Single _____Widowed _____ Separated _____ Divorced

How many children do you have? _____ Occupation: _____

Do you currently smoke? _____Yes _____ No If yes, how many packs per day? _____

If no, have you ever smoked? ____Yes _____ No

Do you drink alcohol? _____Yes _____ No If yes, how often? _____

FAMILY HISTORY (check all that apply)

____ Heart disease
____ Lung disease
____ High blood pressure
____ Strokes
____ Prostate disease
____ Kidney disease or stones
____ Diabetes
____ Arthritis
____ Cancer
____ Tuberculosis
____ Neurological problems

Physician use only

PATIENT'S NAME: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS

Do you currently have any problems related to the areas outlined below? Please circle all that apply.

- **GENERAL**

  Weight change Loss of appetite Night sweats Fatigue Nausea Fever Chills

___ *Negative review*

- **HEAD/EYES/EARS/NOSE/THROAT**

  Headaches/Migraines Hearing problems Ringing in ears Nasal congestion Eye pain
  Dental problems Dry mouth Difficulty swallowing Vision problems/Glaucoma Sore throat

___ *Negative review*

- **RESPIRATORY**

  Cough Phlegm Bloody phlegm Shortness of breath

___ *Negative review*

- **CARDIOVASCULAR**

  Chest pain Irregular heart beat Leg cramps Easy bruising Varicose veins

___ *Negative review*

- **GASTROINTESTINAL**

  Pain with swallowing Stomach pain Vomiting Bloody stools Black stools
  Constipation Diarrhea

___ *Negative review*

- **NEUROLOGICAL**

  Numbness Tremor Double-vision Balance problems Poor memory

___ *Negative review*

- **MUSCULOSKELETAL**

  Weakness Difficulty walking Bone or join pains Loss of muscle mass

___ *Negative review*

- **ENDOCRINE**

  Excessive thirst Temperature intolerance Breast pain or lump Nipple discharge
  Decreased libido

___ *Negative review*

- **SKIN**

  Change in skin or nail texture Itchy skin Hives Dry skin Hair loss

___ *Negative review*