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*