MEDICAL HISTORY

Patient Name _____ Age _____ Today's Date _____

Marital Status: _____ How did you hear about us (physician, friend, ad)? _____

CURRENT OCCUPATION (please also state if retired) _____

Referring Physician _____ Family Doctor _____

HISTORY OF PRESENT ILLNESS

REASON for today's visit _____

LOCATION of the problem _____

On a scale of 1-10 (10 being the most severe) circle the number that best describes the problem.

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other_____

Does anything make the problem better or worse?

Moving around Standing up Lying on my side

Other_____

How long does the problem last?

__Seconds __Minutes __Hours Always there

Describe the problem Constant or Variable?

Dull, Sharp or both Very sharp then leaves

Other:_____

Is anything else occurring at the same time?

YES NO If yes, please explain_____

Does the problem interfere with your normal functions?

YES NO If yes, please explain _____

Would you like to discuss erectile function?

YES NO

Would you like to discuss urine incontinence?

YES NO

PAST MEDICAL & SOCIAL HISTORY

CIRCLE ALL OF THE FOLLOWING THAT APPLY

PERSONAL HISTORY OF:

ALCOHOLISM	HEART ATTACK	PROSTATE	PARKINSON'S
ARTHIRITIS	HEART MURMUR	CANCER	DISEASE
ASTHMA	HEPATITIS	HIGH BLOOD	SEIZURE/ STROKE
CANCER(ANY)	HERNIA: type	PRESSURE	RECURRENT
DIABETES	HIGH	KIDNEY STONES	BLADDER/KIDNEY
EMPHYSEMA	CHOLESTEROL	MULTIPLE	INFECTIONS
GOUT		SCLEROSIS	

OTHER: _____

PAST SURGICAL HISTORY OF:

PROSTATE	HYSTERECTOMY	HIP/KNEE	BACK/NECK
BLADDER	URETHRA	REPLACEMENT	CANCER (specify)
CIRCUMCISION	HERNIA	GALL BLADDER	
KIDNEY STONE	VASECTOMY	VASECTOMY	Other
KIDNEY	INTESTINES	HEART	

FAMILY HISTORY OF:

PROSTATE CANCER KIDNEY STONES OTHER_____

Do you now or did you ever smoke? Y N How many packs/day ____Years smoked____When quit? ____

Do you drink alcoholic beverages? Y N **Do you take Aspirin or any blood thinner?** Y N

Have you ever had a blood transfusion? Y N **Are you on a special diet?** Y N

Do you have allergies to any medications? Y N **Are you sexually active?** Y N

Please list _____

Are you taking any prescription or non-prescription medications? Y N

Please list medications and dosages: