

UROLOGY SPECIALISTS, P.C.

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. This information will not be released to anyone without your authorization.

Today's Date:

Date of Birth:

Name *(Last, First, M.I.):*

Reason for visit/Chief Complaint:

PAST MEDICAL HISTORY

Please list all prior surgeries

Date	Surgery	Date	Surgery

Please list all past and current medical conditions

Date Diagnosed	Medical Condition	Date Diagnosed	Medical Condition

List your prescribed and over-the-counter drugs, including vitamins

Name of Drug	Strength	Frequency Taken

Allergies

Name of Drug	Reaction

Patient Name:

Date of Birth:

Today's Date:

SOCIAL HISTORY

Personal: Marital Status (circle one): Single / Married / Divorced / Separated / Widowed
Please list number of children and their ages:
What is your religious affiliation, if any? Do you live alone?
What is your primary language? Do you have vision or hearing loss?
Do you have an Advanced Directive or Living Will?
Alcohol: Do you drink alcohol?
Tobacco: Do you smoke?
Drugs: Do you currently or have you used recreational or street drugs?

FAMILY HISTORY

Does anyone in your family have a history of any of the following: (Please circle all that apply):

- Kidney Stones, Adrenal Cancer, Urinary Tract Infections, Diabetes, Thyroid Disease
Kidney Cancer, Bladder Cancer, Heart Problems, Tuberculosis, Bleeding Disorders
Kidney Disease, Prostate Cancer, High Blood Pressure, Alcoholism, Anesthesia Problems
Polycystic Kidneys, Testicular Cancer, Lung Problems, Strokes, None Apply

Other Cancer (specify):

REVIEW OF SYSTEMS

Do you now have or have you had any of the following?
Fever/ Chills, Weight loss, Shortness of breath, Wheezing, Recent productive cough, Exposure to tuberculosis, Chest pain, Abnormal blood pressure, Ankle swelling, Heart murmur, Heart attack, Artificial heart valve, Blood in urine, Leaking urine, Frequent urinary infections, Blurred vision, Glaucoma, Paralysis/weakness, New back pain, Arthritis, Artificial joint, Latex allergy, Hay Fever, Previous blood transfusion, Skin rash, Excessive thirst, Decreased sex drive, Diabetes, Thyroid problems, Feel depressed, Considering suicide, Abdominal pain, Nausea/Vomiting, Constipation, Ulcer disease, Dizzy spells, Numbness, Stroke

Immunization History: Tetanus, Flu Shot, Pneumovax, Other:

For Doctor Use Only (sign/date)

Patient Name:

Date of Birth:

Today's Date:

MALE HEALTH INVENTORY

Please answer the following questions regarding URINARY SYMPTOMS and ERECTILE FUNCTION by circling the appropriate answer below:

URINARY INVENTORY

Please circle the answer that most accurately relates to you.

Table with 6 columns: Never, < 1 time in 5, < half the time, About half the time, > half the time, Almost always. Row 1: 0, 1, 2, 3, 4, 5

1. Incomplete Emptying: Sensation of not emptying your bladder completely after you have finished urinating

Table with 6 columns: 0, 1, 2, 3, 4, 5

2. Frequency: Urinating again < 2 hrs after urination

Table with 6 columns: 0, 1, 2, 3, 4, 5

3. Intermittency: How often have you found you stopped and started again several times when you urinated?

Table with 6 columns: 0, 1, 2, 3, 4, 5

4. Urgency: Difficulty postponing urination

Table with 6 columns: 0, 1, 2, 3, 4, 5

5. Weak Urinary Stream:

Table with 6 columns: 0, 1, 2, 3, 4, 5

6. Straining: Pushing or straining to begin urination

Table with 6 columns: 0, 1, 2, 3, 4, 5

7. Nocturia: How many times do you get up to urinate from the time you went to bed at night until the time you get up in the morning? (circle the # of times/night)

Table with 6 columns: 0, 1, 2, 3, 4, 5

Total of 7 items above: _____

SEXUAL INVENTORY

I have been using

Table with 4 columns: Viagra, Cialis, Levitra, Muse, Vacuum Device, Penile Injection. Each with Yes/No checkboxes.

Please circle the number of the response that best describes your own situation over the past 3 months.

1. Rate your confidence that you could get & keep an erection

Table with 5 columns: Very Low, Low, Moderate, High, Very High. Row 1: 1, 2, 3, 4, 5

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

Table with 6 columns: No sexual activity, Almost never, A few times, Sometimes, Most times, Almost always. Row 1: 0, 1, 2, 3, 4, 5

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

Table with 6 columns: 0, 1, 2, 3, 4, 5

4. When you attempted sexual intercourse, how often was it satisfactory to you?

Table with 6 columns: 0, 1, 2, 3, 4, 5

5. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

Table with 6 columns: No sexual activity, Extremely difficult, Very difficult, Difficult, Slightly difficult, Not difficult. Row 1: 0, 1, 2, 3, 4, 5

Total of 5 items above: _____

Have you had your prostate surgically removed for prostate cancer? Yes No If yes, date of operation: _____

If yes, do you leak any urine? Yes No If yes, how many pads per day do you wear to keep dry? _____

If your prostate was removed, have you had an erection satisfactory for vaginal penetration since the surgery? Yes No