MEDICAL HISTORY

Patient Name _____ Age _____ Today's Date _____

Marital Status: _____ How did you hear about our office? _____

CURRENT OCCUPATION (please 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?

___days ago ___weeks ago ___months ago

Other _____

Does anything make the problem better or worse?

Moving around Standing up Lying down

Other_____

How long does the problem last?

__Seconds __Minutes __Hours

Describe the problem Constant or Variable?

Dull, Sharp or both

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, SURGICAL & SOCIAL HISTORY

CHECK ALL OF THE FOLLOWING THAT APPLY

PERSONAL HISTORY OF:

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

PERSONAL SURGICAL HISTORY OF:

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

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 What kind:_____ Amount Daily:_____

Do you take Aspirin or a blood thinner? Y N **Have you ever had a blood transfusion?** Y N

Are you on a special diet? Y N **Are you sexually active?** Y N

Please list any **ALLERGIES** (and the reaction):_____

Please list **MEDICATION** and **DOSAGES**: _____