PATIENT HISTORY FORM

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?
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

Do you or your partner experience pain or discomfort during intercourse?
YES NO

PAST MEDICAL & SOCIAL HISTORY

CIRCLE ALL OF THE FOLLOWING THAT APPLY

PERSONAL HISTORY OF:

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

PAST SURGICAL HISTORY OF:

- ❑ PROSTATE
- ❑ BLADDER
- ❑ CIRCUMCISION
- ❑ KIDNEY STONE
- ❑ KIDNEY
- ❑ HYSTERECTOMY
- ❑ URETHRA
- ❑ HERNIA
- ❑ VASECTOMY
- ❑ INTESTINES
- ❑ HIP/KNEE REPLACEMENT
- ❑ GALL BLADDER
- ❑ APPENDECTOMY
- ❑ 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	**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 any allergies?	Y	N	**Are you sexually active?**	Y	N

Please list allergies (and the reaction) _____

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

over →

Please list medications and dosages _____