

**UROLOGY ASSOCIATES LTD**

**HEALTH HISTORY FORM**

**DATE:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Dr's phone#:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Dr's phone#:** \_\_\_\_\_

**Sex:** Female \_\_\_\_\_ Male \_\_\_\_\_ **Reason for visit:** \_\_\_\_\_

**Duration of above complaint** Please indicate number \_\_\_\_ week(s) \_\_\_\_ month(s) \_\_\_\_ year(s)

**Have you been treated for this condition in the past?** Yes No If yes, please explain

**Frequency of urination:** Daytime \_\_\_\_ Nighttime \_\_\_\_ **Strength of stream** Normal \_\_\_\_ Decreased \_\_\_\_

Poor \_\_\_\_

Physician use only:

**MEDICAL PROBLEMS:** (PLEASE CIRCLE THE APPROPRIATE PROBLEMS THAT PERTAIN TO YOUR HEALTH)

NONE HIGH BLOOD PRESSURE HEART DISEASE DIABETES STROKES COPD/ASTHMA GLAUCOMA  
ARTHRITIS THYROID OTHER \_\_\_\_\_

**SURGICAL PROCEDURES:** (PLEASE CIRCLE THE SURGERY AND/OR SURGERIRS THAT YOU HAVE HAD)

NONE HEART BYPASS INGUINAL HERNIA REPAIR GALLBLADDER HYSTERECTOMY/BSO  
VASECTOMY APPENDECTOMY ORTHOPEDIC PROSTHESES-HIP SHOULDER KNEE- RIGHT OR LEFT  
TONSILLECTOMY OTHER \_\_\_\_\_



## REVIEW OF SYSTEMS

Do you have any of the following problems? Circle Yes or No

### Constitutional Symptoms

Fever	Yes	No
Chills	Yes	No
Weight loss	Yes	No
Other _____		

### Musculoskeletal

Joint pain	Yes	No
Neck pain	Yes	No
Back pain	Yes	No
Other _____		

### Eyes

Blurred vision	Yes	No
Double vision	Yes	No
Pain	Yes	No

### Integumentary

History of jaundice	Yes	No
Skin rash	Yes	No
Boils	Yes	No
Persistent itch	Yes	No
Other _____		

### Ears/Nose/Throat/Mouth

Ear infection	Yes	No
Hearing Aid	Yes	No
Sore throat	Yes	No
Hoarseness	Yes	No
Change in swallowing	Yes	No
Sinus Problems	Yes	No
Other _____		

### Gastrointestinal

Abdominal pain	Yes	No
Indigestion/heartburn	Yes	No
Nausea/vomiting	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Blood in stool	Yes	No
Black stool	Yes	No
History of ulcer	Yes	No
Other _____		

### Cardiovascular

Chest pain	Yes	No
Heart palpitations	Yes	No
History of heart attack	Yes	No
High blood pressure	Yes	No
Varicose veins	Yes	No

### Gynecological

Are you presently pregnant	Yes	No
Last menstrual date _____		
Menopause-if yes, age _____		
Difficulty having intercourse	Yes	No

### Respiratory

Asthma	Yes	No
Wheezing	Yes	No
Chronic cough	Yes	No
Shortness of breath	Yes	No
Other _____		

### Neurologic

Headache	Yes	No
Tremors	Yes	No
Dizzy spells	Yes	No
History of fainting/seizures	Yes	No
History of numbness/weakness	Yes	No
Other _____		

### Hematologic/Lymphatic

Blood clotting problems	Yes	No
Easy bruising	Yes	No
Swollen glands	Yes	No
Other _____		

### Psychologic

History of depression	Yes	No
Other _____		

### Endocrine

Are you a diabetic?	Yes	No
Excessive thirst	Yes	No
Too hot/cold	Yes	No
Tired/sluggish	Yes	No
Hypo/Hyperthyroidism	Yes	No

### Infections/Sexually Transmitted Diseases

Hepatitis	Yes	No
HIV/AIDS	Yes	No
Chlamydia	Yes	No
Genital Herpes	Yes	No
Genital Venereal Warts	Yes	No
Syphilis	Yes	No
Other _____		

**Males Only:**  
**AUA SYMPTOM INDEX**

<b>Circle ONE number in each column that best answers the following questions:</b>	<b>Not at all</b>	<b>Less than 1 times in 5</b>	<b>Less than half the time</b>	<b>About half the time</b>	<b>More than half the time</b>	<b>Almost always</b>
1. Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Over the past month or so, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. Over the past month or so, how often have you found it difficult to postpone urinating?	0	1	2	3	4	5
5. Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. On average, how many times do you most typically get up to urinate from the time you went to bed at night until the time you get up in the morning?	0	1	2	3	4	5

**SEXUAL HEALTH INVENTORY FOR MEN**

Select the number that best describes your situation. Enter that number in the blank to the left of the question. Please be sure that you select only one response to each question.

**Over the past 6 months:**

- \_\_\_ A) How often do you rate your confidence that you could get and keep an erection?  
 1) Very low      2) Low      3) Moderate      4) High      5) Very high
- \_\_\_ B) When you had erections with sexual stimulation, how often were erections hard enough for penetration (entering your partner)?  
 0) No sexual activity      1) Almost never or never      2) A few times-less than ½  
 3) Sometimes-1/2 the time      4) Most times-more than ½      5) Almost always
- \_\_\_ C) During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?  
 0) Did not attempt intercourse      1) Almost never or never      2) A few times-less than ½  
 3) Sometimes-1/2 the time      4) Most times-more than ½      5) Almost always
- \_\_\_ D) During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?  
 0) Did not attempt intercourse      1) Extremely difficult      2) Very difficult  
 3) Difficult      4) Slightly difficult      5) Not difficult
- \_\_\_ E) When you attempted sexual intercourse, how often was it satisfactory for you?  
 0) Did not attempt intercourse      1) Almost never or never      2) A few times-less than ½  
 3) Sometimes-1/2 the time      4) Most times-more than ½      5) Almost always