

MEDICAL HISTORY

TODAY'S DATE _____

NAME _____ AGE _____ REFERRED BY _____

PRIMARY PHYSICIAN _____

REASON FOR OFFICE VISIT _____

HAVE YOU HAD:

Daytime urination
Number of times _____

Urinary burning or pain
 Infection of bladder or kidneys
 Blood in urine

Night urination
Number of times _____

Incomplete bladder emptying
 Loss of urine with cough
 Run to urinate

CURRENT MEDICATIONS (include Aspirin and herbs)

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

ALLERGIES (medications, foods, etc. Please describe reaction)

PAST SURGICAL HISTORY:

<u>OPERATION</u>	<u>DATE</u>	<u>OPERATION</u>	<u>DATE</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

FAMILY HISTORY (If alive, age and health; if deceased, age at death/cause)

MOTHER _____ **FATHER** _____

Any blood relatives with a history of prostate, bladder, kidney or other urologic disorders, cancer or stones? _____

Do you smoke? _____ YES _____ NO Did you smoke? _____ YES _____ NO

If so, how many packs per day? _____ How long _____ quit _____

Alcohol _____ YES _____ NO if yes, how much and how often? _____

Beer _____ Wine _____ Hard liquor _____

MEDICAL HISTORY – PLEASE LIST ALL MEDICAL PROBLEMS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST (Please circle the correct answer)

Bleeding Problems	YES	NO	Blood transfusions	YES	NO
Steroid/prednisone	YES	NO	Anemia	YES	NO
Diabetes	YES	NO	Thyroid problems	YES	NO
Strokes	YES	NO	Stomach ulcers	YES	NO
Phlebitis	YES	NO	Constipation	YES	NO
Fevers	YES	NO	Hiatal hernia	YES	NO
Glaucoma	YES	NO	Diarrhea	YES	NO
Hepatitis	YES	NO	TB (tuberculosis)	YES	NO
High blood pressure	YES	NO	Valley fever	YES	NO
Heart problems	YES	NO	Asthma	YES	NO
Heart attack	YES	NO	Emphysema/Bronchitis	YES	NO
Chest pain	YES	NO	Pneumonia	YES	NO
Heart failure	YES	NO	Epilepsy/Seizures	YES	NO
Ankle swelling	YES	NO	Rheumatic fever	YES	NO
Most recent EKG	YES	NO	Cancer	YES	NO
Most Date:			Where		
Heart murmur	YES	NO	Artificial joint	YES	NO
Weight loss			Parkinson's		YES NO
If yes, how much _____			Mumps	YES	NO
Over how long _____			Other _____		
Are you trying to lose	YES	NO			

HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS IN THE LAST YEAR

MALES

- Loss of sexual ability
- Loss of sexual desire
- Discharge (pus) from penis
- Painless "sore/lesion" on penis

GENERAL

- Excessive fatigue
- Unexplained loss of weight
- Warmer feeling than others
- Colder feeling than others
- Anemia
- Easy bruising or bleeding

FEMALES

- Painful intercourse
- Vaginal discharge
- Vaginal abnormalities
- Are you still menstruating

SKIN

- Itching of skin
- Skin rash
- Pimples or boils
- Growing or non-healing "sores"
- Jaundice (yellow skin & eyeballs)
- Dry skin or hair

HEAD & NECK

- Headaches
- Head injury
- Neck pain
- Dizzy spells or fainting
- Eye trouble (not including glasses)
- Blurred vision
- Trouble hearing
- Trouble talking
- Trouble swallowing
- Nose bleeds
- Frequent colds, sore throats
- Hay fever, other allergy
- Neck pain

DIGESTIVE TRACT

- Food sticking in throat
- Loss of appetite
- Nausea
- Vomiting
- Vomiting of blood
- Heartburn
- Indigestion
- Gas or bloating
- Stomach trouble
- Colitis or bowel trouble
- Diverticula (outpouchings)
- Constipation
- Diarrhea
- Change in bowel habits
- Rectal distress
- Rectal bleeding
- Black bowel movements

HEART & LUNGS

- Chest pain or tightness
- Shortness of breath
- Wheezing or asthma
- Rapid or irregular heartbeat
- Chronic, persistent cough
- Coughing of blood

BONES & JOINTS

- Arthritis
- Bursitis
- Joint pain
- Joint stiffness
- Back pain
- Sciatic nerve pain
- Broken bones

EXTREMITIES

- Weakness of arm, hand or leg
- Trouble walking in the dark
- Varicose veins
- Vein inflammation (phlebitis)
- Foot or ankle swelling
- Night cramps in legs
- Leg distress while walking

NERVOUS SYSTEM

- Trouble sleeping
- Trembling hands
- Worries or fears
- Tensions at work or home
- Depressed or "blue" feelings
- Nervous breakdown
- Psychiatric care or treatment

OCCUPATION _____ **DATE OF BIRTH** _____

SIGNATURE _____ **DATE** _____