HISTORY AND PHYSICAL

Name: _____ Date:_____ Age:_____

Have you ever been seen previously in this office? YES NO If yes, when?_____

***Please answer all questions. If the question does not apply to you, please write "n/a."

YES NO Pain or burning with urination?

YES NO Painful bladder?

YES NO Double voiding? (Need to void within 5 minutes of last void)

YES NO Post-void dribbling?

YES NO Blood in urine at any time?

YES NO Slow urinary stream?

YES NO Difficulty starting urination?

YES NO Inability to hold urine (wet pants)?

YES NO Bedwetting?

YES NO Kidney infections?

YES NO Kidney stones?

YES NO Bladder infections?

YES NO Recent fever or chills?

YES NO Urinating too frequently (more than 6 times a day)?

YES NO Awakening to urinate more than once in a night?

YES NO Have you ever been to a Urologist before?

YES NO Have you had kidney or bladder X-rays before?

YES NO Have you had any Sexually Transmitted Diseases (STDs)?

*Next 3 questions for men only:

YES NO Have you had any prostate infections (prostatitis)?

YES NO Any difficulties with erections?

YES NO Discharge from penis?

*Next several questions for women only:

YES NO Are your periods normal? If not, describe.

YES NO Have you had surgery on your uterus or ovaries? What year?

YES NO Have you had bladder surgery? What year?

If applicable, when was your last period?_____

Number of pregnancies?_____ Number of births?_____ Miscarriages/Abortions?_____

MORE QUESTIONS ON BACK SIDE

List any illnesses/diseases or major injuries and the year they occurred:

_____

_____

List prior surgeries and the year, whether or not they are related to urology:

_____

_____

Do you smoke? YES NO Have you smoked? YES NO Year you quit?_____
Packs per day?_____ Number of years you've smoked?_____

Do you drink alcohol? YES NO Drinks per day?_____

Do you take aspirin or any other blood-thinning products? YES NO
If yes, please specify what you take:_____

In the event that you needed a blood transfusion:

- ❑ I would accept blood from a blood bank or by donating my own blood.
- ❑ I would not accept any blood products of any type.

List all medicines and dosages you are currently taking:
(*Please use a separate sheet of paper if you need more space)

_____

_____

List all medicines you are ALLERGIC to:_____

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Has anyone in your family had?... (circle) Cancer Tuberculosis Diabetes

Heart Disease High Blood Pressure Kidney Failure Kidney Stones

Age and health problems of: Mother_____ Father_____

Sister_____ Brother_____

****

Do you have problems with?... (circle all that apply)

Weight gain/loss Dizziness Appetite Fever Tiredness Insomnia Headache

Vision Hearing Nose Voice Swallowing Throat Chest Pain Breathing

Palpitations High Blood Pressure Stomach Aches Constipation Diarrhea

Bloody Stools Walking Weakness Arthritis Swelling of Limbs Strokes

Seizures Diabetes Bruising Bleeding