Maui Urology

MEDICAL HISTORY

Patient Name _____ Age_____ Today's Date_____
Marital Status: _____ How did you hear about us (physician, friend, ad)?_____
OCCUPATION (please also state if current or 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 0

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: _____
Very sharp and then leaves

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 (E.D.)?
YES ◯ NO ◯

Would you like to discuss urine incontinence (leak)?
YES ◯ NO ◯

PAST MEDICAL & SOCIAL HISTORY

CHECK ALL OF THE FOLLOWING THAT APPLY

PERSONAL HISTORY OF:

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

OTHER: _____

PAST SURGICAL HISTORY OF:

☐ PROSTATE	☐ HYSTERECTOMY	☐ HIP/KNEE REPLACEMENT	☐ BACK/NECK
☐ BLADDER	☐ URETHRA	☐ GALL BLADDER	☐ CANCER (specify)
☐ CIRCUMCISION	☐ HERNIA	☐ INTESTINES	
☐ KIDNEY STONE	☐ VASECTOMY		☐ HEART (specify)

OTHER/Explain: _____

FAMILY HISTORY OF:

☐ PROSTATE CANCER ☐ KIDNEY STONES OTHER: _____

SOCIAL HISTORY OF:

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 ◯

Have you ever had a blood transfusion? Y ◯ N ◯
Do you take Aspirin or blood thinner? Y ◯ N ◯
Are you on a special diet? Y ◯ N ◯
Are you sexually active? Y ◯ N ◯

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Do you have allergies to any medications? Y N
Please list:

_____

_____

_____

Are you taking any prescription or non-prescription medications? Y N
Please list medications and dosages:

Medication Name	Dose	Medication Name	Dose

REVIEW OF SYSTEMS

Do you now or have you had any recent problems related to the following systems? Circle **Yes** or **No**.
Please explain any Yes answers in space provided.

Constitutional Symptoms
Fever Y N
Other/Comments _____

Eyes
Recent Vision Changes Y N
Other/Comments _____

Cardiovascular
Chest Pain Y N
Other/Comments _____

Respiratory
Cough Y N
Shortness of breath Y N
Other/Comments _____

Gastrointestinal
Abdominal pain Y N
Nausea/vomiting Y N
Other/Comments _____

Hematologic/Lymphatic
History of Blood Clots
(DVT or PE) Y N
Other/Comments _____

Genitourinary
Urine retention (can't void) Y N
Urine incontinence (leakage) Y N
Urinary frequency Y N
Painful urination Y N
Erection difficulties Y N
Vaginal Dryness or pain w sex Y N
Other/Comments _____

Musculoskeletal
Back Pain Y N
Other/Comments _____

Integumentary
Skin rash/lesions Y N
Other/Comments _____

Neurological
Headaches Y N
Lightheadedness Y N
Other/Comments _____

Psychiatric
Anxiety Y N
Other/Comments _____