CEDARS-SINAI MEDICAL CENTER®

Academic Urology Practice

PATIENT MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____

Age:_____ Date of Appointment:_____

Primary Doctor:_____

Referring Doctor:_____

Urologist:_____

Current Medications	**Dose**
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____
7._____	_____
8._____	_____
9._____	_____

Are you allergic to any medications? ◯YES ◯NO
If yes, please list medication name(s) and reaction(s):_____

If you have every had surgery before, please list below:

	Type of Surgery	Date of Surgery
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Check all that apply

Have you ever taken Aspirin or blood thinning medications? ☐
If yes, list medication and explain why/when:_____

Have you ever had a heart attack? ☐

Do you ever experience chest pain or angina? ☐

Do you have any known heart disease or ailments? ☐
(murmurs, abnormal rhythm, etc.)

Do you have elevated blood pressure? ☐

Have you ever been diagnosed with any lung disease? ☐
(tuberculosis, emphysema, asthma, pneumonia, etc.)

Have you ever smoked cigarettes? ☐
If yes, how much?:_____

Have you ever had a stroke or other neurologic disorders? ☐

Have you ever had diabetes? ☐

Have you ever had hepatitis or liver disease? ☐

Have you ever had stomach or duodenal ulcers? ☐

Have you ever had back problems? ☐
If yes, explain:_____

Have you ever had problems with vision? ☐
(glaucoma, cataracts, etc.)

REVIEW OF SYSTEMS

Are you currently, or have you ever had, problems with (Check all that apply):

General:

- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Excessive Fatigue
- ☐ Night Sweats

Ear, Nose, Throat and Mouth:

- ☐ Trouble Hearing
- ☐ Sinus Problems
- ☐ Sinus Headaches
- ☐ Painful or Difficulty Swallowing
- ☐ Mouth Sores

Cardiovascular:

- ☐ Chest Pain or Angina(Date of Last EKG:_____)
- ☐ Palpitations
- ☐ High Cholesterol
- ☐ Shoulder Pain

Cardiovascular (cont'd):

- ☐ Buttock or Calf Pain with Exertion
- ☐ Swelling in Feet or Hands
- ☐ Leg Pain while Walking

Respiratory:

- ☐ Chronic Cough
- ☐ Painful Breathing
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Lung Cancer
- ☐ Bloody Sputum
- ☐ Date of Last Chest X-Ray:_____

Gastrointestinal:

- ☐ Indigestion
- ☐ Nausea or Vomiting
- ☐ Weight Loss
- ☐ Blood in the Stool
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation

- ☐ Bleeding from the Rectum
- ☐ Appetite Disturbance
- ☐ Ulcers
- ☐ Gastritis

Genitourinary:

- ☐ Urinary Tract Infections
- ☐ Painful or Burning w/Urination
- ☐ Blood in your Urine
- ☐ Leaking of Urine
- ☐ Frequent Urination
- ☐ Difficulty Starting Stream of Urine
- ☐ Difficulty Emptying Bladder
- ☐ Waking to Urinate (how often):_____
- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Prostate Cancer (males)
- ☐ Endometriosis (females)
- ☐ Uterine or Cervical Cancer (females)

Gynecologic:

Menstrual Periods

- ☐ Regular?
- ☐ Painful?

- ☐ Abnormal Vaginal Bleeding
- ☐ Unusual Discharge
- ☐ Painful Intercourse
- ☐ Breast Swelling or Tenderness
- ☐ Breast Masses
- ☐ Nipple Discharge

Stone History:

Is this your first stone? ☐ YES

Is your current stone on the right or left side? ☐ RIGHT ☐ LEFT

How long have you known about this stone?_____

If you have had stones in the past, answer the following:

Total number of stones on the right side_____ left side_____ unknown_____

Number of stones passed spontaneously without intervention: right side____left side____

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Adult Male Medical History Form

I. Have you had more than one PSA MEASUREMENT or PROSTATE BIOPSY in the past? If yes, please complete the chart below:

	DATE	PSA VALUE	BIOPSY RESULT
1.			
2.			
3.			
4.			
5.			
6.			
7.			

II. Do you have normal erections?

- ☐ YES
- ☐ NO
- ☐ YES (but does not last)

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Urologic Oncology Medical History (continued)

Is there any family history of cancer? ☐ Yes ☐ No If "yes" who? _____

What kind? _____

(Please check those that apply)

Mother: Living: ☐ age: ____ **Father**: Living: ☐ age: ____
Healthy: ☐ Healthy: ☐
Deceased: ☐ Deceased: ☐
Death caused by _____ Death caused by _____

Sibling: Living: ☐ ☐
Healthy: ☐ Healthy: ☐
Deceased: ☐ Deceased: ☐
Death caused by _____ Death caused by_____

What is your most recent occupation? _____

Please check one for each of the following categories:

MARITAL STATUS: ◯ Single ◉ Married ◯ Life Partner ◯ Widowed ◯ Divorced

ALCOHOL CONSUMPTION: (No. of drinks): ◉ None ◯ 1-3 per day ◯ 4-6 per day ◯ More than 6

TOBACCO CONSUMPTION: ◉ None ◯ Less than 1 pack/day ◯ 1 pack/day ◯ 2 or more pack/day ◯ Quit: When?___/___/___

Be sure to save the form to your computer and then email it to your doctor's practice as an attachment.