

MEDICAL HISTORY

Marital Status: How did you hear about us (physician, friend, ad)? OCCUPATION (please also state if current or retired) Family Doctor Referring Physician HISTORY OF PRESENT ILLNESS REASON for today's visit HISTORY OF PRESENT ILLNESS COLORATION of the problem Describe the problem Constant or Variable? On a scale of 1-10 (10 being the most severe) Duil, Sharp or both, Very sharp then leaves circle the number that best describes the problem. Describe the problem Constant or Variable? 1 2 3 4 5 6 7 8 9 10 0 Uher: 2 days ago 2 weeks ago 0 cos anything make the problem better or worse? Moving around Standing up Other: Very sharp and then leaves Usery sharp and then leaves Very sharp and then leaves Usery sharp and then leaves Usery sharp and then leaves Other: Woold you like to discuss erectile function (E.D.)? YES Seconds Minutes Ohors PAST MEDICAL & SOCIAL HISTORY CHECK ALL OF THE FOLLOWING THAT APPLY PERSONAL HISTORY OF: CALCER (ANY) HEART MURNUR ARTHRITIS HACAT MURNUR HEART MURNUR CALCER (ANY) HEART MURNUR HIGH CHOLESTEROL MULTIPLE SCLEROSIS GOUT OTHER: PROSTATE HISH CHOLESTEROL MULTIPLE SCLEROSIS GOUT MIGH CHOLESTEROL </th <th>Patient Name</th> <th></th> <th>Age Tod:</th> <th>ay's Date</th>	Patient Name		Age Tod:	ay's Date		
Referring Physician	Marital Status:					
Referring Physician	OCCUPATION (please also	o state if current or retired)				
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 0 Other: Describe the problem tast? Seconds 2 Minutes 2 Hours 2 Always there Woold you like to discuss erectile function (E.D.)? YES 0 NO 1 if yes, please explain Woold you like to discuss erectile function (E.D.)? YES 0 NO 0 Woold you like to discuss erectile function (E.D.)? YES 0 NO 0 Woold you like to discuss erectile function (E.D.)? YES 0 NO 0 Woold you like to discuss urine incontinence (leak)? YES 0 NO 0 Woold you like to discuss urine incontinence (leak)? YES 0 NO 0 Wee discuss urine incontinence (leak)? YES 0 NO 0 Wee discuss urine incontinence (leak)? YES 0 NO 0 Wee discuss urine incontinence (leak)? YES 0 NO 0 Wee discuss urine incontinence (leak)? YES 0 NO 0 Wee discuss urine incontinence (leak)? YES 0 NO 0 Bactorent discuss urine incontinence (leak)? <td></td> <td>HISTORY OF F</td> <td>PRESENT ILLNESS</td> <td></td>		HISTORY OF F	PRESENT ILLNESS			
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Other:			Is anything else occurring at the same time?			
Does anything make the problem better or worse? Does anything make the problem better or worse? Moving around Standing up O Lying on my side Other:		ago \bigcirc 1 month ago \bigcirc				
Moving around Standing up Uying on my side Other: YES O NO O If yes, please explain Would you like to discuss erectile function (E.D.)? YES O NO O Mow long does the problem last? Oseconds O Minutes O Hours O Hours Past MEDICAL & SOCIAL HISTORY YES O NO O YES O NO O Past MEDICAL & SOCIAL HISTORY YES O NO O Past MEDICAL & SOCIAL HISTORY YES O NO O Past MEDICAL & SOCIAL HISTORY YES O NO O Past MEDICAL & SOCIAL HISTORY CHECK ALL OF THE FOLLOWING THAT APPLY PESONAL HISTORY OF: ALCOHOLISM HEART MURMUR BLADDER DIABETES DIABETES HIGH CHOLESTEROL MULTIPLE SCLEROSIS GOUT OTHER: PAST SURGICAL HISTORY OF: KIDNEY STONE VASECTOMY </td <td></td> <td></td> <td colspan="3">Does the problem interfere with your normal</td>			Does the problem interfere with your normal			
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Do you drink alcoholic beverages? YONO Are you sexually active? YONO				Are you on a special diet? YONO		
	Do you drink alcoholic bever	rages? YONO	Are you sexually active			



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 <u>recent problems</u> related to the following systems? Circle **Yes** or **No**. **Please explain any Yes answers in space provided.**

Constitutional Symptoms Fever Other/Comments Eyes Recent Vision Changes Other/Comments	γO	N O	Genitourinary Urine retention (can't void) Urine incontinence (leakage) Urinary frequency Painful urination Erection difficulties Vaginal Dryness or pain w sex		
		_	Other/Comments		-
Cardiovascular Chest Pain Other/Comments	уO		Musculoskeleta l Back Pain Other/Comments	уO	N O
Respiratory Cough Shortness of breath Other/Comments	y O y O	-	Integumentary Skin rash/lesions Other/Comments	YО	N O
Gastrointestinal Abdominal pain Nausea/vomiting Other/Comments	ү О ү О	-	Neurological Headaches Lightheadedness Other/Comments	чО YO	N 0 N 0
Hematologic/Lymphatic History of Blood Clots (DVT or PE) Other/Comments	уO	N O	Psychiatric Anxiety Other/Comments	уO	N О _