

MEDICAL HISTORY

Patient Name	A	\ge	Today's Date			
Marital Status:	How did you he	ear about us (physiciar	, friend, ad)?			
OCCUPATION (please also state if cur	rent or retired)					
Referring Physician		Family Doctor				
	HISTORY OF PE	RESENT ILLNESS				
REASON for today's visit						
LOCATION of the problem						
On a scale of 1-10 (10 being the mos	-	·	blem Constant or Variable?			
circle the number that best describes	s the problem.	Dull, Sharp or both, Very sharp then leaves Other:				
When did you first notice the proble	m?					
2 days ago 2 weeks ago 1 month ago		Is anything else occurring at the same time?				
Other:	-	YES NO If yes, please explain Does the problem interfere with your normal				
Does anything make the problem be		functions?	il iliteriele with your normal			
Moving around Standing up Lying on my side		YES NO If yes, please explain				
Other:		Would you like to discuss erectile function (E.D.)?				
How long does the problem last?		YES NO				
SecondsMinutesHoursAlways there		Would you like to discuss urine incontinence (leak)? YES NO				
	DAST MEDICAL S	SOCIAL HISTORY				
		LLOWING THAT APPLY				
PERSONAL HISTORY OF:						
·	ART ATTACK	PROSTATE CANCE	RPARKINSON'S DISEASE			
	ART MURMUR	HIGH BLOOD PRESSU				
ASTHMAHE	PATITIS					
CANCER (ANY)HE	RNIA: type	KIDNEY STONES	RECURRENT			
DIADETEC	CHICHOLESTEROL	MILLITIDI E COLEDO	BLADDER/KIDNEY INFECTIONS			
DIABETESHI	GH CHOLESTEROL	MULTIPLE SCLERO	J313GOOT			
						
PAST SURGICAL HISTORY OF	=		DAGW (NIFOW			
		HIP/KNEE REPLACEMIGALL BLADDER	BACK/NECK CANCER (specify)			
			CANCEN (specify)			
CIRCUMCISIONHERN KIDNEY STONE VASE	ICTOMY	INTESTINES	HEART (specify)			
OTHER/Explain:			ILAKT (specify)			
•						
FAMILY HISTORY OF:	NIEV CTONEC	OTLIED.				
PROSTATE CANCERKIE	ONEY STONES	OTHER:				
SOCIAL HISTORY OF:						
Do you now or did you ever smoke? Y N		•	d a blood transfusion? Y N			
How many packs/day Years smoked		Do you take Aspirin or blood thinner? Y N Are you on a special diet? Y N				
When quit? Do you drink alcoholic beverages? Y	N	Are you on a spec Are you sexually a				



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 Genitourinary Fever Y N Urine retention (can't void) Y N Other/Comments Urine incontinence (leakage) Y N Urine incontinence (leakage) Y N Urine incontinence (leakage) Y N Other/Comments Y N Erection difficulties Y N N Erection difficulties Y N N Erection difficulties Y N N Other/Comments Urine incontinence (leakage) Y N N Other/Comments Y N N Lightheadedness Y N N Nausea/vomiting Y N N Lightheadedness Y N N Nausea/vomiting Y N Lightheadedness Y N N Other/Comments Y N N Other/Comm	Do you have allergies to any medications? Y N Please list:										
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 Urine retention (can't void) Y N Urine incontinence (leakage) Y N Urine retention (can't void) Y N Urine retention (can't void) Y N N Eves Painful urination Y N Erection difficulties Y N Other/Comments Y N Erection difficulties Y N Other/Comments Y N N Urine retention (first void) Y N N Erection difficulties Y N N Other/Comments Y N N Headaches Y N N Other/Comments Y N N Lightheadedness Y N N N N Sursea/vomiting Y N N Lightheadedness Y N N Other/Comments Y N N Urine recent y N N Lightheadedness Y N N Other/Comments Y N N Lightheadedness Y N N Other/Comments Y N N Lightheadedness Y N N N N N N N N N N N N N N N N N N		-	-	ption medications? Y N							
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 Urine retention (can't void) Y N Other/Comments Urine incontinence (leakage) Y N Feyes Painful urination Y N Recent Vision Changes Y N Erection difficulties Y N Other/Comments Y N Erection difficulties Y N Other/Comments Y N Musculoskeletal Other/Comments Back Pain Y N Other/Comments Y N	Medication Name Dose		Dose	Medication Name		Dose					
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 Urine retention (can't void) Y N Other/Comments Urine incontinence (leakage) Y N Feyes Painful urination Y N Recent Vision Changes Y N Erection difficulties Y N Other/Comments Y N Erection difficulties Y N Other/Comments Y N Musculoskeletal Other/Comments Back Pain Y N Other/Comments Y N			REVIE	W OF SYSTEMS	-						
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Constitutional Symptoms Fever Y N Urine retention (can't void) Y N Other/Comments Urine incontinence (leakage) Y N Urinary frequency Y N Recent Vision Changes Y N Erection difficulties Y N Other/Comments Vaginal Dryness or pain w sex Y N Other/Comments Y N Musculoskeletal Other/Comments Back Pain Y N Other/Comments Y N Other/Comments N Other/Comments N Respiratory Cough Y N Integumentary Shortness of breath Y N Skin rash/lesions Y N Other/Comments N Other/Comments Y N Other/Comments	Do you now or nav	-			.s. c	0.0 100 0. 110.					
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