Maui Urology

Dr. Soren Carlsen

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

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: _____

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 _____