Advanced Urology Associates of Florida

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MEDICAL HISTORY

Please Print and Fill Out Completely

Name:________________________________ Social Security # : ______/_____/_______ Age: ____ Date: _______________

Reason for today's visit: ____

UROLOGIC HISTORY:

Painful Urination __________________ Blood in Urine ____________ Rectal Pain ____________ Chills _________________

Hesitancy to Start Stream ___________ Urgency to Urinate ________ Back Pain _____________ Fevers ________________

Frequent Urination _________________ How Often ______________________

How many times do you get up at night to urinate? ____

Is your force of stream: ________ Good ________ Fair _________ Poor

Do you feel you empty your bladder completely? ________ Yes _________ No

Do you have involuntary leaking of urine? ________ Yes _________ No

If yes how does this occur? ____ Coughing ____ Straining _____ Sitting _____ Walking _____ Running _____ In bed at night

When you have the urge to urinate, do you leak before reaching the toilet? ________ Yes _________ No

Do you use pads or liners? ________ Yes _________ No If yes, how many each day? ______________________________

Have you ever had Kidney Stones? ________ Yes _________ No If yes, how often have you had them? ________________

Have you ever been told you had a bladder, kidney or prostate problem? ________ Yes _________ No

Have you ever had surgery on your ____ Kidneys _____ Penis _____ Bladder ____ Prostate ____Testicles ____ Urethra (water channel)

PERSONAL HISTORY:

_______ Arthritis
_______ Back problems
_______ Cancer (type) _________________________
_______ Depression
_______ Diabetes (how long) __________________
_______ Glaucoma
_______ Heart Murmur
_______ Heart trouble
_______ Heart valve replacement/problems
_______ High blood pressure
_______ Hepatitis

________ Irregular heart beat
________ Joint replacement (which) __________________
________ Mitral valve prolapse
________ Multiple sclerosis
________ Rheumatic fever
________ Stroke (when) ____________________________
(how many) _________________________
________ Stomach ulcer ___________________________
________ Other __________________________________
________ Other __________________________________
________ Other __________________________________

MEDICATIONS: Prescription, Over-the-counter, Herbal, Vitamins, or Homeopathic:

____

____

____

ALLERGIES? ____

____

Please list any OPERATIONS, HOSPITALIZATIONS or SERIOUS ILLNESS:

____ Date: _______________

____ Date: _______________

____ Date: _______________

____ Date: _______________

____ Date: _______________

____ Date: _______________

SOCIAL HISTORY:

Do you smoke? _____ Yes _____ No If yes, how many packs per day? ______________________________

How long have you smoked? ______________________ When did you quit? ______________________________

Do you consume alcoholic beverages? _____ Yes _____ No If yes, what type of alcohol? ______________________

How often? __________________________ How much? ______________________________

Do you drink caffeinated beverages? Please list how much every day:

Coffee ______________________________ Tea ______________________________

Colas ______________________________ Chocolate ______________________________

SEXUAL HISTORY: (Males Only)

Do you have difficulty obtaining and maintaining an erection satisfactory for intercourse? _____ Yes _____ No

If yes, please continue with the following.

1. How long has this problem been present? ______________________________________
2. When was the last date of sexual intercourse (with penetration)? ______________________________
3. Do you ever awaken with an erection? _____ Yes _____ No
4. If yes, are they in the morning or at night? ______________________________________
5. How full are your erections on a scale from 0 -- 10? ______________________________________
6. When you have an erection, is the penis straight or does it curve to one side or the other? _______________
7. How long does your erection last? ______________________________________
8. Do you satisfy your sexual partner? _____ Yes _____ No
9. Have your erection difficulties affected your relationship with your sexual partner? _____ Yes _____ No
10. Have you seen other physicians for this problem? _____ Yes _____ No
11. Have you utilized any treatment for this problem? _____ Yes _____ No
12. Do you want to cure this problem? _____ Yes _____ No