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PATIENT HISTORY

Read carefully and accurately. This sheet will become part of your permanent file. Please fill out the following information and return to the receptionist.

Patient Name ____ Date ________________________

1. Please summarize the reason for your visit along with your symptoms:

2. How long has this troubled you?

   Is there any situation that may have contributed to this problem?

3. How many times do you urinate: Day Night
4. Any kidney or bladder infections? Y N If yes, number of infections Times per year Starting at what age
5. Have you ever had blood in your urine? Y N If yes, when
6. Have you ever had a kidney stone? Y N If yes, passed & when or operated on & when
7. Do you have urinary incontinence (loss or leakage of urine) ? Y N If yes, ask for questionnaire on arrival.
8. Any change of urinary stream? Y N
   If yes, check:

   Decreased Force Interrupted Stream Hard to Start Dribbling Control Problem Straining to Urinate

   Incomplete Emptying Other:
9. Do you have problems obtaining an erection? Y N
   If yes, ask for questionnaire if you would like evaluation and treatment.
10. Previous x-rays of kidneys? Y N If yes, where & when?

Reminder: Please bring x-ray films to your appointment.

PREGNANCIES:

Live births
Still births
Miscarriages
Abortions

MENSTRUATION:

Normal Yes No
Last Menstrual Period

ILLNESSES AND MEDICAL PROBLEMS

Please check any of the following illnesses and medical problems you have or have had in the past. Please indicate the year each started. If you are not certain when an illness started, write down an approximate year.

Illness	Year
Endocrine or glandular disorder	
Anemia	
Asthma	
Tuberculosis	
Lung problems	
High blood pressure	
Heart attack	
Arteriosclerosis (hardening of arteries)	
Heart condition	
Stomach or bowel disorder	
Liver or gallbladder problems	
Kidney or bladder disease	
Kidney or bladder stones	
Prostate problems	
Mental health problems	
Typhoid fever	

Illness	Year
Headaches	
Head injury	
Stroke	
Convulsions, seizures	
Other neurological disorder	
Arthritis	
Gout	
Cancer or tumor	
Bleeding tendency	
Diabetes or tendency toward	
Polio	
Mumps	
Radiation or cobalt treatments	
Venereal disease	
Genital herpes	
Hepatitis	
Rheumatic fever	
Pneumonia	

Please check yes or no if you have or have previously had any of the following symptoms in each system.

NEURO-PSYCHIATRIC:

Yes No Depression
Yes No Nervous breakdown
Yes No Stroke
Yes No Speech disturbances
Yes No Fainting
Yes No Convulsions or epilepsy
Yes No Numbness
Yes No Multiple Sclerosis

CARDIO-RESPIRATORY:

Yes No Chest Pain
Yes No Palpitations
Yes No Heart murmur
Yes No Shortness of breath
Yes No Chronic cough
Yes No Congenital defects
Yes No Spitting up blood
Yes No Night sweats

MUSCULO-SKELETAL:

Yes No Back or neck surgery
Yes No Muscular control loss
Yes No Tremors
Yes No Back injuries
Yes No Joint stiffness
Yes No Limitation of motion
Yes No Leg or knee problems
Yes No Varicose veins
Yes No Parkinson's disease
Yes No Muscular dystrophy

GASTROINTESTINAL:

Yes No Normal bowel habits
Yes No Frequent diarrhea
Yes No Blood in stool
Yes No Ulcers
Yes No Frequent upset stomach
Yes No Hemorrhoids
Yes No Constipation

I have reviewed the foregoing statement: This information is true and correct to the best of my knowledge.

Date: ________ Patient Signature:______________________ Physician Signature:________________________

MEDICATIONS Please list all medications you are now taking, including those you take without a doctor's prescription.

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

ALLERGIES Please list all allergies to medicines

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

PLEASE LIST ALL HOSPITALIZATION, SURGERIES, AND INJURIES BELOW

YEAR	OPERATION, ILLNESS, INJURY	HOSPITAL & CITY
_____	____________________________________	____
_____	____________________________________	____
_____	____________________________________	____

Do you drink alcohol? Y N
If yes, how many drinks per day? ____beers
____glasses of wine ____drinks of hard liquor
Do you drink coffee or tea? Y N
____________ cups per day.
How many after 5 p.m.? ____

Do you smoke? Y N If yes, how many years?
How many each day? _____cigarettes _______cigars
Have you ever smoked? Y N If yes, how many years?____
How many each day? _____cigarettes_____cigars______pipe
If you have quit, when? ____

FAMILY HISTORY

Have anv BLOOD RELATIVES had any of the following illnesses? If so, indicate the relationship (mother, father, brother, sister, etc.)

Illness	**Family Member**
High Blood Pressure	___________________________
Heart Disease	___________________________
Diabetes	___________________________
Cancer	___________________________
Kidney Stones	__________________________
Gout	___________________________
Polycystic Kidneys	___________________________
Lung Disease	___________________________
Tuberculosis	___________________________
Peptic Ulcer	___________________________
Psychosis	___________________________