

Swedish Urology Group

Patient History Form – Male

Note: This is a confidential record and will be kept as part of your chart. Information provided here will not be released to anyone without your authorization to do so.

Name: _____ Today's Date: _____

Date of Birth: ____ / ____ / ____ Age: ____ Social Security No: _____

Were you referred to our office by another physician? Yes / No

If yes, name _____ Phone _____

CURRENT PROBLEM

What is the main problem that brings you to the office today? (Describe your symptoms in detail)

When did you first notice the problem or symptoms?: _____

Where in your body do the symptoms arise? _____

Do they travel or go anywhere _____

Had you experienced any similar symptoms in the past? _____

Are the symptoms continuous, variable, or only occasionally present? _____

When present, how long do they last? _____

How severe are the symptoms that arise at the same time? _____

Do you notice any other symptoms that arise at the same time? _____

What seems to make the symptoms worse (activity, food, etc.)? _____

What seems to make the symptoms better? _____

Do the symptoms interfere with your normal function? _____

PAST MEDICAL HISTORY

Please list all illnesses requiring medical treatment, surgery, or hospitalization:

Please list current/recent medications:
(Include dose, how often and date began)

MEDICATION ALLERGIES (Please list reaction)

FAMILY MEDICAL HISTORY

Please list any major illnesses in family members, parents' age or age at death, siblings' age or age at death:

Father _____ Mother _____

Brothers/Sisters _____

Grandparents _____

SOCIAL HISTORY

What is your occupation? _____

Marital Status? _____

Do you live alone? _____

Number of children? _____

Do you smoke currently? Yes/No Years/Amount? _____

Did you smoke in the past? Yes/No Dates _____

How much alcohol do you drink per day? _____

How much caffeine do you use per day? _____

Have you used any recreational drugs? _____



TURN PAGE OVER

Male Urologic

Symptoms/ History

Have you had any of the following in the last six months? Please check/circle any that apply.

- _____ Stones of the kidney, ureter or urinary bladder?
- _____ Cancer of the kidney, ureter, bladder, testicle, or prostate?
- _____ Infection of the prostate, testicle, bladder or kidney?
- _____ Trauma to the kidney, groin, or testicle?
- _____ Herpes, genital warts or gonorrhea?
- _____ Surgery on kidney, bladder, prostate, or penis
- _____ Vaectomy?
- _____ PSA (most recent _____)?

General

- Y N fevers
- Y N chills
- Y N sweats
- Y N anorexia
- Y N fatigue
- Y N malaise
- Y N weight loss

Eyes

- Y N blurring
- Y N double vision
- Y N irritation
- Y N discharge
- Y N vision loss
- Y N eye pain
- Y N light sensitivity

Ears/Nose Throat

- Y N earache
- Y N ear discharge
- Y N ringing
- Y N hearing loss
- Y N nasal congestion
- Y N nosebleeds
- Y N sore throat
- Y N hoarseness
- Y N painful swallowing

Cardiovascular

- Y N chest pains
- Y N palpitations
- Y N dizziness/syncope
- Y N shortness of breath
- Y N short of breath lying down
- Y N sudden nighttime breathlessness
- Y N ankle swelling

Respiratory

- Y N cough
- Y N shortness of Breath
- Y N excessive sputum
- Y N bloody sputum
- Y N wheezing

Gastrointestinal

- Y N nausea
- Y N vomiting
- Y N diarrhea
- Y N constipation
- Y N change in bowel habits
- Y N abdominal pain
- Y N black or tarry stools
- Y N red blood in the stools
- Y N jaundice

Genitourinary

- Y N getting up at night to urinate
- Y N frequent urination
- Y N urgent need to urinate
- Y N urethral pain on voiding
- Y N difficulty starting stream
- Y N slowing of urine stream
- Y N intermittent urine stream
- Y N feeling bladder doesn't empty completely
- Y N incontinence
- Y N blood in the urine
- Y N urethral discharge
- Y N testicular pain
- Y N difficulty with erections
- Y N decreased libido
- Y N vasectomy

Musculoskeletal

- Y N back pain
- Y N joint pain
- Y N joint swelling
- Y N muscle cramps
- Y N muscle weakness
- Y N stiffness
- Y N arthritis

Skin

- Y N rash
- Y N itching
- Y N dryness
- Y N suspicious lesions

Neurologic

- Y N transient paralysis
- Y N weakness
- Y N tingling numbness
- Y N seizures
- Y N dizziness
- Y N tremors
- Y N room spinning

Psychiatric

- Y N depression
- Y N anxiety
- Y N memory loss
- Y N mental disturbance
- Y N thoughts of suicide
- Y N hallucinations
- Y N paranoia

Endocrine

- Y N cold intolerance
- Y N heat intolerance
- Y N constant thirst
- Y N constant hunger
- Y N frequent urination
- Y N weight gain

Heme/Lymphatic

- Y N abnormal bruising
- Y N bleeding
- Y N low blood count
- Y N enlarged lymph nodes

Allergic/Immunologic

- Y N hives
- Y N hay fever
- Y N persistent infections
- Y N HIV exposure