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PATIENT HISTORY FORM

PLEASE PRINT CLEARLY. **DATE**: _____

NAME: _____ **AGE**: _____ **RACE**: _____

MAIN COMPLAINT: _____

_____

_____

PAST HISTORY:

☐Diabetes ☐High Blood Pressure ☐Heart Problems ☐Asthma ☐Bleeding
☐Cancer ☐Ulcers ☐Liver Problems ☐Emphysema ☐Other
☐Previous Surgery

☐Kidney Stones ☐Hernias ☐Impotence ☐Infertility
☐Urinary Infections ☐Bladder Stones ☐Prostate Problems ☐Sexually Transmitted Disease (Venereal Disease)

If you marked any of the above, please explain:

_____
_____
_____
_____

Medications taken at this time: _____
_____

Allergies

☐Penicillin ☐Sulfa ☐Codeine
☐Aspirin ☐Iodine ☐Other (specify):_____
☐NONE

GENITO-URINARY SYSTEM REVIEW:
Please mark all that apply.

Changes in voiding (urination):

☐Frequency ☐Urinating at night ☐Urgency
☐Dribbling ☐Painful urination ☐Discharge
☐Burning ☐Difficulty beginning stream ☐Blood in urine
☐Incontinence ☐Other (specify):_____

Pain:

☐Back or flank ☐Lower abdomen ☐Testicle or scrotum
☐With sexual intercourse ☐Genital ☐Other (specify):_____

Women only:

☐Vaginal discharge ☐Fertility problems
Date of last menstrual period: _____ Number of pregnancies:_____

Men Only:

☐Impotence ☐Genital lesions ☐Swelling of testicles or scrotum