

**Alaska Southcentral Urology Specialists
MEDICAL HISTORY**

Patient's Name: _____ Date: _____

Reason for Today's Visit:

X-rays or blood work pertaining to this visit:

Where: _____ When: _____

Where: _____ When: _____

Past Surgical History: Please list all the surgeries you've had.

Date: _____ Date: _____

Date: _____ Date: _____

Vasectomy? Yes _____ No _____ Hysterectomy? Yes _____ No _____

Past Medical History: Have you ever been treated or are currently being treated for:

Alcoholism: _____ Artificial Joints: _____ Hepatitis/HIV: _____

Drug Abuse: _____ Tuberculosis: _____

Other past medical problems not listed: _____

Patient Social History:

Use of Alcohol? No Yes How much? _____ For How long? _____

Tobacco Use? No Yes (# packs/per day) _____ How many years? _____
Year Quit? _____

Fluid intake per day? Coffee: _____ Tea: _____ Water: _____
Water: _____ Juice: _____ Milk: _____
Soda pop: _____

Do you have any family history of the following?

Cancer _____ Gout _____

Diabetes _____ Heart Disease _____

Hypertension _____ Kidney Problems _____

Other Unlisted Problems _____

Medications: Please list all of your medications including vitamins and over the counter.

Drug: _____ Dose: _____ Drug: _____ Dose: _____

Drug: _____ Dose: _____ Drug: _____ Dose: _____

Drug: _____ Dose: _____ Drug: _____ Dose: _____

Drug: _____ Dose: _____ Drug: _____ Dose: _____

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Nurse/MA: _____ Date: _____

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DO YOU PRESENTLY HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

1. CONSTITUTIONAL SYMPTOMS

Good general health NO YES
Recent weight change NO YES
Fever NO YES
Fatigue NO YES
Headaches NO YES

2. EYES

Eye disease or injury NO YES
Glasses/Contacts NO YES
Glaucoma NO YES

3. CARDIOVASCULAR

Heart Trouble NO YES
Hypertension NO YES
Chest pain or angina NO YES
Palpitations/murmur NO YES
Shortness of breath

with walking or lying flat NO YES

Swelling of hands or feet NO YES

4. RESPIRATORY

Chronic/frequent coughs NO YES
Asthma or wheezing NO YES
Emphysema NO YES

5. GASTROINTESTINAL

Nausea or vomiting NO YES
Frequent diarrhea NO YES
Constipation NO YES
Abdominal pain/ heartburn NO YES
Ulcers NO YES
Difficulty evacuating NO YES

6. GENITOURINARY

Frequent urination NO YES
Burning/painful urination NO YES
Blood in urine NO YES
Change in stream
when urinating NO YES
Urine infections NO YES
Sensations of not emptying
bladder NO YES
Straining to void NO YES
Sudden urges to void NO YES
Intermittent stream NO YES
Difficulty starting stream NO YES
Slow stream NO YES
Urinary dribbling NO YES
Number of pads a day _____
Incontinence NO YES
With urgency NO YES
With Cough/sneeze NO YES
Sexually Transmitted Diseases NO YES

Genitourinary continued

Urinary dribbling NO YES

of times you void @night _____

Kidney stones NO YES

Kidney infections NO YES

MEN

Testicle pain NO YES

Erectile Dysfunction NO YES

Prostate Problems NO YES

WOMEN

of pregnancies _____ # of deliveries _____

of miscarriages _____ # of abortions _____

Date of last Pap smear: _____
results _____

Date of last menstrual period: _____

Method of birth control: _____

Pain with intercourse NO YES

7. MUSCULOSKELETAL

Back pain NO YES

Difficulty in walking NO YES

Arthritis NO YES

Gout NO YES

8. NEUROLOGICAL

Paralysis NO YES

Stroke NO YES

Head injury NO YES

Back injury NO YES

9. PSYCHIATRIC

Depression NO YES

Insomnia NO YES

10. ENDOCRINE

Thyroid disease NO YES

Diabetes NO YES

Excessive thirst NO YES

Excessive urination NO YES

11. HEMOTOLOGIC/LYMPHATIC

bleeding problems NO YES

bruising easily NO YES

Blood clotting problem NO YES

Anemia NO YES

Phlebitis NO YES

Past transfusions NO YES

12. ALLERGIC/IMMUNOLOGIC

Penicillin NO YES

Sulfa NO YES

Morphine/Demerol NO YES

Aspirin NO YES

Novocaine/Lidocaine NO YES

IVP dye, x-ray contrast NO YES

Other (please list): NO YES