Urology Specialists of West Florida

UROLOGY SPECIALISTS OF WEST FLORIDA

PATIENT HISTORY FORM

NAME_____ TODAY'S DATE _____ DATE OF BIRTH _____

REFERRED TO OUR PRACTICE BY _____

CHIEF COMPLAINT/ REASON FOR VISIT _____

_____

WHAT PREVIOUS TREATMENT HAVE YOU HAD FOR THIS PROBLEM? By which doctor? _____

_____

HISTORY OF PRESENT ILLNESS: Location of problem: (circle) Abdomen Back Leg Other_____

When did you notice the problem (Circle) 2 days ago 2 weeks ago 1 month ago Other_____

What helps/makes the problem better or worse: (circle) Moving around Standing up Lying on side Other_____

How long does the problem last? (Circle) 30 minutes 1 hour It is always there Other_____

Is the problem constant or variable? (Circle) Dull then sharp Very sharp then leaves Always there Other_____

Does the problem interfere with normal functions? (Circle) Yes No If yes explain_____

UROLOGICAL HISTORY

Do you now have or ever had any of the following?

Kidney stones ( ) NO ( ) YES Comments_____

Frequent urination ( ) NO ( ) YES _____

Trouble starting stream ( ) NO ( ) YES _____

Pain/burning with urination ( ) NO ( ) YES_____

Difficulty holding urine (urgency) ( ) NO ( ) YES_____

Incomplete emptying of bladder ( ) NO ( ) YES_____

Ever had kidney x-rays? ( ) NO ( ) YES_____

Blood in urine ( ) NO ( ) YES Comments_____

Urinate more than 2 x night ( ) NO ( ) YES _____

Decrease size/force of stream ( ) NO ( ) YES_____

Kidney/bladder infection ( ) NO ( ) YES _____

Loss of urine with coughing/sneezing ( ) NO ( ) YES_____

Gonorrhea/ Syphilis/Herpes ( ) NO ( ) YES _____

Bedwetting as a child? ( ) NO ( ) YES_____

MALES ONLY: Scrotal Swelling ( ) NO ( ) YES _____

Difficulty with erection ( ) NO ( ) YES _____

Erections firm for vaginal penetration ( ) NO ( ) YES_____

Do you have orgasms? ( ) NO ( ) YES ( ) SOMETIMES

Discharge from or sore on penis ( ) NO ( ) YES_____

Mumps involving testicles ( ) NO ( ) YES_____

Do you lose erection during intercourse? ( ) NO ( ) YES

How long since last intercourse ( ) WEEKS ( ) MONTH ( ) YRS

Name of Medication/Over the counter meds/Vitamins/Herbal meds	Strength	# of Times Taken per Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

LIST YOUR PHARMACY NAME AND LOCATION:_____

ALLERGIES TO ANY MEDICATIONS OR FOODS OR IV CONTRAST/X-RAY DYE:_____

_____

PAST MEDICAL HISTORY: (CHECK all that apply to you)

( ) High blood pressure
( ) Diabetes
( ) Heart Attack
( ) Stroke
( ) Atrial fibrillation (irregular heart rate)
( ) Arthritis
( ) Glaucoma
( ) hypothyroid
( ) Kidney stones
( ) Cancer: Type:_____
( ) Enlarged prostate (BPH)
( ) Erectile dysfunction
( ) Kidney failure
( ) High cholesterol
( ) Emphysema (COPD)
( ) Asthma
( ) sleep apnea
( ) Mitral valve prolapse
( ) Blood clot in legs (DVT)
( ) Anemia
( ) chronic back pain
( ) Depression/Anxiety
( ) Neurologic problem

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE _____

_____

PREVIOUS SURGERIES:

( ) Appendectomy
( ) Gall Bladder/Cholecystectomy
( ) Tonsillectomy
( )Heart Surgery
( ) Joint replacement surgery: Type:_____
( ) Pacemaker or AICD defibrillator
( ) Kidney stone surgery: Type:_____
( ) Prostate surgery: Type: _____
( ) Bypass surgery (CABG)
( )Kidney surgery
( ) Hysterectomy
( ) Hernia repair
( ) Bladder surgery: Type:_____
( ) Heart Valve surgery
( ) colon/bowel surgery

OTHER SURGERIES NOT LISTED ABOVE_____

_____

FAMILY HISTORY: Has anyone in your family had? (Circle if yes) Prostate Cancer Kidney Stones Kidney Cancer bladder cancer

Is your mother living? YES NO If NO, year deceased_____ Age at death_____

Is your father living? YES NO If NO, year deceased_____ Age at death_____

Urology Specialists of West Florida

UROLOGY SPECIALISTS OF WEST FLORIDA
PATIENT HISTORY FORM

SOCIAL HISTORY:

TOBACCO/ ALCOHOL USAGE:

Do you smoke cigarettes? YES NO How many packs per day? _____

If NO, have you ever smoked? YES NO When did you quit? _____

Do you drink alcohol? Never Occasional Daily # Drinks per day_____

ARE YOU : ___MARRIED ___DIVORCED ___SINGLE (NEVER MARRIED) ___WIDOWED

Number of Children?_____

What do you do for work?_____ ( ) Retired ( ) Disabled

REVIEW OF SYSTEMS: Please check Yes or No

General/Constitutional		**Neurologic**	
Headache	( ) Yes ( ) No	Dizziness	( ) Yes ( ) No
Chills	( ) Yes ( ) No	Numbness/Tingling	( ) Yes ( ) No
Fever	( ) Yes ( ) No	Tremor	( ) Yes ( ) No
Opthalmologic		**Musculoskeletal**	
Blurring of vision	( ) Yes ( ) No	Neck pain	( ) Yes ( ) No
Double vision	( ) Yes ( ) No	Back pain	( ) Yes ( ) No
Eye Pain	( ) Yes ( ) No	Joint pain	( ) Yes ( ) No
Glaucoma	( ) Yes ( ) No		
HEENT/Neck		**Dermatologic**	
Ear Infection	( ) Yes ( ) No	Boils	( ) Yes ( ) No
Sinus Problems	( ) Yes ( ) No	Itching	( ) Yes ( ) No
Sore Throat	( ) Yes ( ) No	Rash	( ) Yes ( ) No
Endocrine		**Hematology**	
Excessive thirst	( ) Yes ( ) No	Swollen Glands	( ) Yes ( ) No
Too hot/too cold	( ) Yes ( ) No	Blood Clotting problem	( ) Yes ( ) No
Fatigue	( ) Yes ( ) No		
Respiratory		**Psychiatric**	
Cough	( ) Yes ( ) No	Insomnia	( ) Yes ( ) No
Shortness of Breath	( ) Yes ( ) No	Anxiety	( ) Yes ( ) No
Wheezing	( ) Yes ( ) No	Depression	( ) Yes ( ) No
Cardiovascular			
Chest Pain	( ) Yes ( ) No	COMMENTS: _____	
High Blood Pressure	( ) Yes ( ) No	_____	
Varicose Veins	( ) Yes ( ) No	_____	
Gastrointestinal			
Abdominal Pain	( ) Yes ( ) No		
Heartburn/Indigestion	( ) Yes ( ) No		
Nausea/Vomiting	( ) Yes ( ) No		
Urologic			
Urinary Retention	( ) Yes ( ) No		
Painful Urination	( ) Yes ( ) No		
Urinary Frequency	( ) Yes ( ) No		

Please fill out if any issues with urinating:

(AUA Symptom Score) In the past month:	Not at all	<1 in 5 times	< ½ times	About ½ the time	> ½ times	Almost always	Your score
How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
How often have you had to urinate less than every 2 hours?	0	1	2	3	4	5	
How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
How often have you had a weak urinary stream	0	1	2	3	4	5	
How often have you had to strain to start urination	0	1	2	3	4	5	
How many times did you typically get up at night to urinate?	0 times	1 time	2 times	3 times	4 times	5 times	
TOTAL SCORE: 1-7 mild; 8-19 moderate; 20-35 severe	///////	///////	///////	///////	///////	//////	

If you were to spend the rest of your life with your current urinary condition just the way it is now, how would you feel about that?

Circle your response: DELIGHTED----PLEASED----MOSTLY SATISFIED----MIXED----MOSTLY DISSATISFIED----UNHAPPY----TERRIBLE

FOR MEN ONLY (SHIM SCORE): **( ) Please check here if you are not sexually active**

CIRCLE the number that best describes your own situation. Select only 1 answer for each question.

Over the past 6 months:	1	2	3	4	5
How do you rate your confidence that you could get and keep an erection?	Very low	low	moderate	high	Very high
When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	Almost never or never	A few times (<1/2 times)	Sometimes (1/2 times)	Most times (>1/2 times)	Almost always or always
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Almost never or never	A few times (<1/2 times)	Sometimes (1/2 times)	Most times (>1/2 times)	Almost always or always
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never or never	A few times (<1/2 times)	Sometimes (1/2 times)	Most times (>1/2 times)	Almost always or always
SCORE (If < 21, speak to your doctor):	//////////////	//////////////	//////////////	//////////////	//////////////