

TO BE COMPLETED BY PATIENT

UROLOGIC HISTORY

Please Check

- # Urinate/day, # Urinate/night, Urgent need to urinate, Burning Pain, Blood in urine, Straining to urinate, Delay in starting to urinate, Interrupted stream, Slow/weak stream, Dribble after urinating, Feeling of incomplete emptying, Leakage of urine, Kidney stones, Discharge, Back pain, Impotence, Venereal disease, Testicular pain/swelling

UROLOGIC SURGERY: (and date of each)

FLUID INTAKE (Amt.) daily

Water, Coffee, Alcohol, Pop, Milk/Juice

URINARY TRACT INFECTIONS

in last year, date of last infection

DIAGNOSED MEDICAL ILLNESSES

Check all conditions you have had: (x)

- Glaucoma, Cataracts, Asthma, Bronchitis, Emphysema, Tuberculosis, Arrhythmia, Coronary Artery Disease, Murmur, hepatitis (past or active), Ulcers, Gall Stones, Fibromyalgia, COPD, Arthritis, Rheumatoid arthritis, Osteoarthritis, Pneumonia, Psychiatric, Heart Attack, Rheumatic Fever, Mitral Valve Prolapse, Colitis, Alcohol Abuse, Drug Abuse, High Blood Pressure, Disc Disease, CHF, Multiple Sclerosis, Stroke, Parkinson's Disease, Seizures Disorder, Alzheimer's Disease, Anemia, Phlebitis, Thyroid Disease, Diabetes: Insulin - Non-insulin, Hormone Disease, Cancer, Other Disease not listed

PAST MEDICAL HISTORY

HOSPITALIZATIONS

OPERATIONS/TREATMENTS

INJURIES

ALLERGIES & REACTION

MEDICATIONS

(Names & Dose)

SOCIAL HISTORY

Occupation, Marital Status, Smoking Yes/No packs/day

FAMILY HISTORY

MOTHER, FATHER, BROTHERS, SISTERS Alive/Deceased Age Health Problems

