

**Patient Medical History-Male**  
**Victoria Urological Associates, PA**

Date: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_ **Primary Care Doctor:** \_\_\_\_\_

**CHIEF COMPLAINT** (Reason for visit): \_\_\_\_\_

**UROLOGIC HISTORY** (Check all that apply):

A. Urinary Symptoms

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Urgent need to urinate?
<input type="checkbox"/>	<input type="checkbox"/>	Frequently need to urinate? If so, how often? _____
<input type="checkbox"/>	<input type="checkbox"/>	Ever awakened from sleep to urinate (Nocturia)? If so, how often? _____
<input type="checkbox"/>	<input type="checkbox"/>	Strain to void
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty starting your urine stream
<input type="checkbox"/>	<input type="checkbox"/>	Weak urine stream
<input type="checkbox"/>	<input type="checkbox"/>	Pain with urination
<input type="checkbox"/>	<input type="checkbox"/>	Pain/Pressure in lower abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Incomplete emptying of your bladder
<input type="checkbox"/>	<input type="checkbox"/>	Dribbling of urine after voiding
<input type="checkbox"/>	<input type="checkbox"/>	Blood in your urine
<input type="checkbox"/>	<input type="checkbox"/>	Incontinence/leakage
<input type="checkbox"/>	<input type="checkbox"/>	History of urinary infections. If so, how many in the past year? _____
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease

B. Prostate

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Infections/Prostatitis
<input type="checkbox"/>	<input type="checkbox"/>	Prostate cancer
<input type="checkbox"/>	<input type="checkbox"/>	BPH (Enlarged Prostate = Non-cancerous)
<input type="checkbox"/>	<input type="checkbox"/>	Most Recent PSA    Date: _____    Value: _____

C. Erectile Dysfunction

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Decreased sexual drive
<input type="checkbox"/>	<input type="checkbox"/>	Decreased rigidity/firmness
<input type="checkbox"/>	<input type="checkbox"/>	Inability to maintain an erection
<input type="checkbox"/>	<input type="checkbox"/>	Unsatisfactory for penetration
<input type="checkbox"/>	<input type="checkbox"/>	Erectile pain
<input type="checkbox"/>	<input type="checkbox"/>	Penile curvature
<input type="checkbox"/>	<input type="checkbox"/>	Absence of morning erections

**MEDICAL HISTORY (Check all that you have been diagnosed with):**

*A. Pulmonary*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	TB
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Embolism

*F. Neurologic*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	MS
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson Disease
<input type="checkbox"/>	<input type="checkbox"/>	Spinal Cord Injury (Level _____)

*B. Cardiovascular*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Valvular Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Prior Angioplasty
<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain w/ walking
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol

*G. Gastrointestinal*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis/Pancreatic Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis
<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Bowel Disease (UC/Crohn's)
<input type="checkbox"/>	<input type="checkbox"/>	Peptic Ulcer Disease
<input type="checkbox"/>	<input type="checkbox"/>	Gastroesophageal Reflux
<input type="checkbox"/>	<input type="checkbox"/>	GI Bleed
<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis

*C. Endocrine*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Hypo/Hyper Thyroidism

*H. Renal Disease*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Renal Failure
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones

*D. Musculoskeletal*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Gout

*I. Eyes*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma

*E. Psychological*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

*J. Hematologic/Immunologic*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding/Clotting Problems
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	History of Blood Transfusions
<input type="checkbox"/>	<input type="checkbox"/>	HIV/Aids
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, if so what type? _____

**PAST SURGICAL HISTORY (List prior surgical procedures and approximate dates):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT MEDICATIONS & DOSAGES (Include Over-the-Counter & Herbal Medicines):**

*\*if you filled out this information on the Patient Information Sheet you may skip this section*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ARE YOU ALLERGIC TO ANY MEDICATIONS? \_\_\_\_ Yes (list below) \_\_\_\_ No**

*\*if you filled out this information on the Patient Information Sheet you may skip this section*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY (Check all that your family members have been diagnosed with):**

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Testicular Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Cancer			

**SOCIAL HISTORY (Check all that apply to you):**

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use If so, What type? _____ Amount: _____ How long? _____ If you answered yes and have quit give the date you quit _____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use If so, What type? _____ Amount: _____ How long? _____ If you answered yes and have quit give the date you quit _____
<input type="checkbox"/>	<input type="checkbox"/>	Illegal Drug Use If so, What type? _____ Amount: _____ How long? _____ If you answered yes and have quit give the date you quit _____

Occupation: \_\_\_\_\_ Retired: \_\_\_\_ Yes \_\_\_\_ No

Marital Status: \_\_\_\_ Single \_\_\_\_ Widower  
\_\_\_\_ Married \_\_\_\_ Other  
\_\_\_\_ Divorced

**REVIEW OF SYSTEMS (Check beside all symptoms you are experiencing):**

*General*

YES NO

- |                          |                          |                    |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Fever              |
| <input type="checkbox"/> | <input type="checkbox"/> | Chills             |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight Loss        |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased Appetite |

*Cardiovascular*

YES NO

- |                          |                          |                |
|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain     |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle Swelling |
| <input type="checkbox"/> | <input type="checkbox"/> | Palpitations   |

*Pulmonary*

YES NO

- |                          |                          |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough               |
| <input type="checkbox"/> | <input type="checkbox"/> | Sputum Production   |

*GI System*

YES NO

- |                          |                          |                    |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea             |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting           |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain     |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea           |
| <input type="checkbox"/> | <input type="checkbox"/> | Bloody Stools      |
| <input type="checkbox"/> | <input type="checkbox"/> | Black Tarry Stools |

*HEENT*

YES NO

- |                          |                          |                       |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss          |
| <input type="checkbox"/> | <input type="checkbox"/> | Nasal Congestion      |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore Throat           |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Swallowing |

*Neurologic*

YES NO

- |                          |                          |                   |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches         |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness/Tingling |
| <input type="checkbox"/> | <input type="checkbox"/> | Memory Loss       |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred Vision    |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Changes    |

*Musculoskeletal*

YES NO

- |                          |                          |            |
|--------------------------|--------------------------|------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness   |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Pain |

*Hematologic*

YES NO

- |                          |                          |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen Lymph Nodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose Bleeds         |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruising            |

*Endocrine*

YES NO

- |                          |                          |             |
|--------------------------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hot Flashes |
|--------------------------|--------------------------|-------------|

*Skin*

YES NO

- |                          |                          |      |
|--------------------------|--------------------------|------|
| <input type="checkbox"/> | <input type="checkbox"/> | Rash |
|--------------------------|--------------------------|------|

**Reviewed by:** \_\_\_\_\_

**Date:** \_\_\_\_\_