Roper St. Francis Healthcare - MEDICAL HISTORY Patient Name: Patient DOB:

Have you seen a urologist before? YES NO If so, Whom? _____

Main reason for seeing the doctor today? _____

LIST ALLERGIES TO MEDICATIONS:	NAME and DOSE OF DAILY MEDICATION:	ALL PREVIOUS SURGERIES/DATES:

Do you:
Smoke? Y N How much? _____ Drink alcohol? Y N How often? _____

Take aspirin daily? Y N Are you on a special diet? _____

Are you Married? Y N Do you have children? Y N If yes how many - Male _____ Female _____

Are your Parents: Living? _____ Deceased? _____ Health Status: _____

Number of siblings: Brothers _____ Sisters _____ Health Status: _____

FAMILY HISTORY: Breast Cancer? Y N If so, whom? Mother Grandmother Sister Self

Prostate cancer? Y N If so, whom? Father Grandfather Brother

HAVE YOU EVER HAD ANY PROBLEMS WITH, OR BEEN TREATED FOR:

BACK TROUBLE	YES	NO	DEPRESSION	YES	NO	PROSTATE GLAND	YES	NO
BLADDER TROUBLE	YES	NO	HEART ATTACK	YES	NO	STOMACH ULCERS	YES	NO
BLOOD PRESSURE	YES	NO	HIV/AIDS	YES	NO	STROKE	YES	NO
BLOOD IN URINE	YES	NO	KIDNEY DISEASE	YES	NO	SUGAR DIABETES	YES	NO
CANCER	YES	NO	KIDNEY STONES	YES	NO	URINE INFECTION	YES	NO
COLON TROUBLE	YES	NO	LUNG DISEASE	YES	NO			

BLADDER SYMPTOMS – ALL PATIENTS PLEASE COMPLETE

Rate the following over the last month Scale: 1 – Not at all 2 – Some 3 – Almost always

The sensation of incomplete emptying after urination?	1	2	3
Feeling a need to urinate again less than 2 hours after urination?	1	2	3
The feeling of stopping and starting urination?	1	2	3
Urgency or difficulty postponing urination?	1	2	3
A weak urinary stream?	1	2	3
Feeling a need to push or strain to begin urination?	1	2	3

How do you feel about your present urinary status? _____ Number of times up at night to urinate? _____

Physician Use Only: