West Coast | Urology

PALETZ AGATSTEIN UROLOGY MEDICAL GROUP, INC

MEDICAL HISTORY

FULL NAME	DATE OF BIRTH	TODAY'S DATE

Reason for today's visit _____

When did you first notice the problem? _____

Level of pain: *(level of pain 1-10, 10 being the worst)* _____

Name of Pharmacy *(must be exact)* _____ Tel # ( )_____

Address of Pharmacy *(must be exact)* _____

MEDICATION

Please list all of your medications including non-prescriptions and vitamins:

	DRUG	DOSE	HOW OFTEN?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

ALLERGIES

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Demerol
- ☐ Iodine, Methiolate or Other
- ☐ Latex Sensitivity
- ☐ Morphine
- ☐ Novocaine/Lidocaine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____
- ☐ None

PAST MEDICAL HISTORY

Please check if you have a history of any of the following:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Bleeding tendency
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Cystic Fibrosis
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Diverticulitis/Diverticulosis
- ☐ Emphysema
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Sinusitis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TB
- ☐ Ulcers
- ☐ Other _____
- ☐ None

MEDICAL HISTORY

FULL NAME	DATE OF BIRTH	TODAY'S DATE

PAST SURGICAL HISTORY

Please check all of the operations that you have had:

- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Bladder Tumor
- ☐ Cataract
- ☐ Coronary Stent
- ☐ C-Section
- ☐ Gall Bladder Removal
- ☐ Heart Bypass
- ☐ Hernia
- ☐ Hydrocele
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Kidney Stone Surgery
- ☐ Prostate
- ☐ Tonsillectomy
- ☐ Undescended Teste
- ☐ Urinary Stone Surgery
- ☐ Vasectomy
- ☐ Other _____
- ☐ None

SOCIAL HISTORY

Do you currently smoke cigarettes?
No ☐
Yes ☐ *If yes:* Year started _____ Amount per day _____

Do you currently smoke cigars?
No ☐
Yes ☐ *If yes:* Year started _____ Amount per day _____

If you smoked in the past but quit:
What year did you quit? _____
How many years did you smoke? _____
How many packs per day did you smoke? _____

Passive Smoke Exposure: Yes ☐ No ☐

Illegal Drug Use: Yes ☐ No ☐

HIV High Risk Behavior: Yes ☐ No ☐

Alcohol Use:
No ☐
Yes ☐ *If yes:* Indicate how much you drink: ☐ Social ☐ Moderate ☐ Heavy

Caffeine Use:
No ☐
Yes ☐ *If yes:* Number of drinks per day _____

Occupation _____ If retired, former occupation? _____

FAMILY HISTORY

Please check any diseases that run in your immediate family:

Father ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Kidney Failure ☐ Kidney Stone ☐ Prostate ☐ Stroke
☐ Other _____

Mother ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Kidney Failure ☐ Kidney Stone ☐ Stroke
☐ Other _____

Brother ☐ Prostate Cancer ***Uncle*** ☐ Prostate Cancer

MEDICAL HISTORY

FULL NAME	DATE OF BIRTH	TODAY'S DATE

Please check if you presently have any of the following:

CARDIOVASCULAR
- ☐ Edema
- ☐ Chest pain or angina pectoris
- ☐ Heart trouble
- ☐ Hypertension
- ☐ Palpitation
- ☐ Shortness of breath lying flat
- ☐ Shortness of breath with walking
- ☐ Swelling of feet, ankles or hands

CONSTITUTIONAL
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Recent failure of general health
- ☐ Recent weight change

ENDOCRINE
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Thyroid disease
- ☐ Tired/Sluggish
- ☐ Too hot/cold

GASTROINTESTINAL
- ☐ Abdominal pain or heartburn
- ☐ Blood in stool
- ☐ Constipation
- ☐ Frequent diarrhea
- ☐ Nausea or vomiting
- ☐ Peptic ulcer (stomach or duodenal)

GENITOURINARY
- ☐ Frequent urination
- ☐ Painful or burning urination
- ☐ Blood in urine
- ☐ Change in force of stream when urinating
- ☐ Urinary tract infections
- ☐ Sensation of incomplete emptying
- ☐ Straining to void
- ☐ Sudden urges to void
- ☐ Intermittent stream
- ☐ Difficulty starting stream
- ☐ Slow stream
- ☐ Incontinence or dribbling
  - No. of pads used _____
- ☐ Incontinence
  - ☐ with urgency
  - ☐ with cough/sneeze
- ☐ Urinary dribbling

No. of times you void at night _____
- ☐ Kidney stones
- ☐ Kidney infections

HEENT
- ☐ Cataracts
- ☐ Eye disease or injury
- ☐ Ear Infection
- ☐ Glaucoma
- ☐ Headaches
- ☐ Sinus trouble
- ☐ Sore Throat
- ☐ Wear glasses/contact lenses

HEMATOLOGICAL/LYMPHATIC
- ☐ Anemia
- ☐ Aortic aneurysm
- ☐ Bleeding or bruising tendency
- ☐ Blood clotting problems
- ☐ Past transfusion
- ☐ Phlebitis
- ☐ Swollen glands
- ☐ Varicose veins

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Back pain
- ☐ Difficulty in walking
- ☐ Gout

NEUROLOGICAL
- ☐ Back injury
- ☐ Dizziness
- ☐ Head injury
- ☐ Paralysis
- ☐ Seizures
- ☐ Stroke
- ☐ Tremors

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Suicidal thoughts

RESPIRATORY
- ☐ Asthma or wheezing
- ☐ Blood in sputum
- ☐ Chronic or frequent coughs
- ☐ Emphysema
- ☐ Shortness of breath

MALE
- ☐ Blood in semen
- ☐ Poor erections
- ☐ Testicular pain
- ☐ Testicular mass or hernia

FEMALE
- ☐ Pelvic pain
- ☐ Vaginal pain
- ☐ Breast lump
- ☐ Menopause

No. of pregnancies _____

No. of deliveries _____

No. of miscarriages _____

No. of abortions _____

Date of last pap smear

_____

Date of last menstrual period

_____

Method of birth control

_____

Are you sexually active? Yes ☐ No ☐

Pain with intercourse? Yes ☐ No ☐