Urodocs
Modern Compassionate Urology

New Patient Medical History

Patients Name: ____ **Date:** ______/______/______

(*Female*) Are you pregnant? ______ Last Menstrual Period: ______/______/______

(*Male*) Last PSA Result: ______ DATE of PSA: ______/______/______

Allergic to any Medications/What happens:

- ____________________ ____________________
- ____________________ ____________________
- ____________________ ____________________

Entire Surgical History:

Year and Procedure

- ____________________ ____________________
- ____________________ ____________________

Past Medical History(Please circle and List Details)

- Diabetes (type/years): Yes/No__________ Other Endocrine Disease: Yes/No______________
- Kidney Disease/Dialysis: Yes/No__________ Hypertension: Yes/No______________
- Cardiac Disease (CHF, Infarcts, etc): Yes/No __________ Neurological Disease (Strokes, etc): Yes/No ______________
- Respiratory/Lung/Breathing problems (COPD, Asthma, etc): Yes/No ______________________
- Gastrointestinal Disease (GERD/Reflux/Sprue/Colitis/Ulcers, etc): Yes/No ______________________
- Orthopedic Problems: Yes/No__________ Bleeding Disorders (hemophilia, etc): Yes/No __________
- Eye Disease (**Glaucoma**, Cataracts): Yes/No ________ Skin Disease (Psoriasis, etc): Yes/No __________
- Psychiatric Disease (Anxiety/Depression): Yes/No ______________
- Any History of Cancer: Yes/No ______________________
- Any Other Medical Problems: ______________________

Family Medical History (Please circle and add as needed)

Prostate Cancer: Yes/No __________ Bladder Cancer: Yes/No__________
Kidney Cancer: Yes/No __________ Testis Cancer: Yes/No______________
Diabetes, Cardiac Disease, Hypertension, Bleeding Disorder: Yes/No______________
Congenital Disease/Birth Defects: ______________________

Social history: (Yes/No How much?)

Cigarettes______ Alcohol______

Current Review of Systems: (Please circle and list details):

- **Constitutional**: wt loss/gain; Fever; Chills; Malaise: Yes/No______________
- **Eyes**: Sudden vision change; pain, Dry eyes: Yes/No______________
- **ENT**: Nose bleeds; Severe Hearing loss: Yes/No______________
- **Respiratory**: difficulty breathing, recent infections: Yes/No______________
- **Cardiovascular**: Chest pain; palpitations: Yes/No______________
- **GI**: Nausea; Vomiting; Constipation; Diarrhea; Abdominal Pain: Yes/No______________
- **Psych**: Anxiety; Depression: Yes/No______________
- *Male* **Genital**: Erection issues; Ejaculation problem: Yes/No______________
- *Female* **Genital**: Discharge; Painful intercourse; Misc. : Yes/No______________
- **Urological Irritative**: Frequency; urgency; burning: Yes/No______________
- **Incontinence** : Yes/No ______________
- **Urological Obstructive**: retention; weak / slow stream; hesitancy: Yes/No______________
- **Blood in urine:** (when? How much?) Yes/No______________
- **Neurological**: seizures; hallucinations; numbness/tingling: Yes/No______________
- **Endocrine:** hair loss; increased thirst; Heat/Cold Intolerance: Yes/No______________
- **Heme**: Easy bleeding; night sweats: Yes/No______________
- **Skin Problems** : Yes/No______________