METROUROLOGY

Patient Medical History – Adult Male

Patient Label

Height _____ Weight_____

Emergency contact person: Name: _____Phone: _____

Who referred you for this consultation? (Self? Doctor? If so, from what clinic?) _____

Describe the location/symptom/problem that is the reason for your visit:_____

_____

Circle the severity number of the problem on a scale of 1-10: (1=low) 1 2 3 4 5 6 7 8 9 10 (10=high)

When did this problem start?_____

Does anything make this problem better or worse? Please describe:_____

_____

Please circle/check the response that most accurately relates to you.

Problem	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
Sensation of not emptying bladder.	0	1	2	3	4	5
Urinating less than 2 hours after urination	0	1	2	3	4	5
Stopping & starting during urination	0	1	2	3	4	5
Difficulty in postponing urination	0	1	2	3	4	5
Weak urinary stream	0	1	2	3	4	5
Pushing/straining during urination	0	1	2	3	4	5
How many times do you urinate from the time you go to bed at night until you get up?	0 times	1 time	2 times	3 times	4 times	5 times

Total of the 7 circled items above_____

Problem	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Do you experience any pain with urination? ☐ No ☐ Yes

Do you experience leaking urine? ☐ No ☐ Yes

Do you have blood in your urine? ☐ No ☐ Yes

Are you experiencing any impotence problems? ☐ No ☐ Yes

Have you ever had a kidney or bladder infection? ☐ No ☐ Yes

Physician use only: (Comments/Notes)

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

Are you or a blood **relative** having problems (now or in the past) with any of the following? ☐ No ☐ Yes
If yes, please check all boxes that apply.

	You	Family Member
Anemia	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Type of cancer:		
Depression	☐	☐
Diabetes	☐	☐
GERD / Acid Reflux	☐	☐
Gout (high uric acid)	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Kidney Stones	☐	☐
Liver Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Osteoporosis	☐	☐
Rheumatic Fever	☐	☐
Thyroid Problems	☐	☐
Toxic Exposure	☐	☐
Tuberculosis	☐	☐
Other/Explain:	☐	☐

Have you had **surgery** on any of the following? ☐ No ☐ Yes
If yes, please check all boxes that apply. INCLUDE SURGERY DATE:

Appendix	☐
Back	☐
Bladder	☐
Breast	☐
Colon	☐
Gallbladder	☐
Heart Bypass	☐
Heart Valve	☐
Hernia	☐
Incontinence	☐
Kidney	☐
Lung	☐
Prostate	☐
Testicle	☐
Thyroid	☐
Total Joint Replacement	☐
Right: ☐ Hip ☐ Knee	☐ Shoulder
Left: ☐ Hip ☐ Knee	☐ Shoulder
Urethra	☐
Vasectomy	☐
Other/Explain:	☐

Have you ever had MRSA? ☐ No ☐ Yes
Positive Mantoux/PPD? ☐ No ☐ Yes

Do you have any allergies? ☐ No ☐ Yes If yes, please list: Latex allergy? ☐ No ☐ Yes

Allergy	Type of Reaction (rash, nausea, etc.)

Are you taking Aspirin, Coumadin, blood thinners?
☐ No ☐ Yes

Are you taking any medications including herbal and over the counter? ☐ No ☐ Yes
If yes, please list:

Name of Medication	Dose	How many times a day?

Do you or did you ever smoke? ☐ No ☐ Yes
If yes:
How many packs per day? _____

How many years? _____
When did you quit? _____

Do you drink alcohol? ☐ No ☐ Yes
If yes, how much? _____

Are you on a special diet? ☐ No ☐ Yes
If yes, explain: _____

Are you married? ☐ No ☐ Yes
☐ Divorced
☐ Widowed

Are you employed? ☐ No ☐ Yes ☐ Retired
What is your occupation? _____

Do you have children? ☐ No ☐ Yes
Year(s) of Birth: _____

REVIEW OF SYSTEMS

Do you have any problems related to the following systems? Please circle No or Yes.

Constitutional Symptoms

Fever	No	Yes
Chills	No	Yes
Headache	No	Yes
Other_____	No	Yes

Eyes

Blurred vision	No	Yes
Double vision	No	Yes
Pain	No	Yes
Other_____	No	Yes

Neurological

Tremors	No	Yes
Dizzy spells	No	Yes
Numbness/tingling	No	Yes
Other_____	No	Yes

Endocrine

Excessive thirst	No	Yes
Too hot/cold	No	Yes
Tired/sluggish	No	Yes
Other_____	No	Yes

Gastrointestinal

Abdominal pain	No	Yes
Nausea/vomiting	No	Yes
Indigestion/heartburn	No	Yes
Other_____	No	Yes

Cardiovascular

Chest pain	No	Yes
Varicose veins	No	Yes
High blood pressure	No	Yes
Other_____	No	Yes

Integumentary

Skin rash	No	Yes
Boils	No	Yes
Persistent itch	No	Yes
Other_____	No	Yes

Musculoskeletal

Joint pain	No	Yes
Neck pain	No	Yes
Back pain	No	Yes
Other_____	No	Yes

Ear/Nose/Throat/Mouth

Ear infection	No	Yes
Sore throat	No	Yes
Sinus problems	No	Yes
Other_____	No	Yes

Allergic/Immunologic

Hay fever	No	Yes
Drug allergies	No	Yes
Other_____	No	Yes

Hematologic/Lymphatic

Swollen glands	No	Yes
Blood clotting problem	No	Yes
Other_____	No	Yes

Respiratory

Wheezing	No	Yes
Frequent cough	No	Yes
Shortness of breath	No	Yes
Other_____	No	Yes

Genitourinary

Urine retention	No	Yes
Painful urination	No	Yes
Urinary frequency	No	Yes
Other_____	No	Yes

Psychologic

Are you generally satisfied with your life?	No	Yes
Do you feel severely depressed?	No	Yes
Have you ever considered suicide?	No	Yes
Other_____	No	Yes

Physician use only: (Comments/Notes)

Physician Signature:_____ ***Date:***_____