**NAME:** ______________________________ **AGE:**__________ **DATE:** ____________

. **CC**: **What Is The Present Reason That You Are Seeing The Doctor Today?**

______________________________________________________________________

**Last doctors office visit** ______________________________ **Last Blood Tests** ______________

**Present height** ______________ **Weight** __________

**If you were injured**, is this a work related injury? Yes No(if yes, did you file an accident report with your employer? **Yes / No**)

**Describe location, severity & duration of symptoms and anything that makes it better:** __________

______________________________________________________________________

℞ Medications taken for this problem in past______________________________________________

Have you seen another doctor for this problem? Yes / No______________________________________

. **Hx Present Illness:** COMMENTS: On a scale of **1-10**, with **10 being the most severe** (or worst symptoms) and 1 being the best, indicate the number that best describes the symptoms of your problem on the right side of the question. ***Check YES OR NO***

☺ 😐 ☹

**B**est…**1…2…3…4…5…6…7…8…9…10**…….. **W**orst

G**Yes** G**No**C Do You Have **Any Difficulty Urinating?:** ______________________________

G**Yes** G**No**C Is The **Force Of Your Urination Poor? Ans. No If Good?**______________________________

G**Yes** G**No**C Does The **Urine Stream Stop In The Middle Of Urinating:?**__________________________

G**Yes** G**No**C Does Your **Bladder Feel Full After Urinating?:**______________________________

G**Yes** G**No**C Do You Have To **Urinate Soon Again After Urinating?: ?**__________________________

G**Yes** G**No**C Do You Have To **Strain Or Push To Urinate:?** ______________________________

G**Yes** G**No**C Have You Had Any **Prior Urological Treatment ?:** ______Last Treated? ______________

G**Yes** G**No**C When You Urinate Do You Have To **Run To The Bathroom Urgently?:** ______________

G**Yes** G**No**C Do You Ever **Lose Your Urine In Your Pants?(When You Cough Or Sneeze):** __________

G**Yes** G**No**C Are You Going To The Bathroom **Frequently** To Urinate**?:** ______________________

G**Yes** G**No**C Do You Have Any **Burning** When You Urinate**?:** ______________________________

G**Yes** G**No**C Do You Have Any **Prior History Of Urinary Tract Infections?:** ____________________

G**Yes** G**No**C Have You Ever Had **Blood On Your Urine** That You Were Able To See Yourself**?** __________

G**Yes** G**No**C Do You Have Any **Back Pains?:**______________________________________________

G**Yes** G**No**C Have You Ever Had Any History Of **Venereal Disease?:**______________________________

G**Yes** G**No**C Have You Ever Had **Kidney Stones?:**______________________________________

G**Yes** G**No**C Do You Have Any **Sexual Problems?:**______________________________________

**PastFamily SocialHx:**

G**Yes** G**No**C Do You Or Any Of Your Family Members Have A History Of Cancer**?:** ______________

G**Yes** G**No**C Do You Smoke?, If Yes How Much & Long ______________________________

G**Yes** G**No**C Do You Drink Alcohol Or Use Drugs?, If Yes, What Type, How Much, & Long ______________

. **PAST SURGERY** Yes / No (Include Type And Year**):**______________________________________

______________________________________________________________________

℞ **MEDICATIONS** YOU ARE TAKING**, Include Dosage And Times A Day Taken ?** ______________________

______________________________________________________________________

______________________________________________________________________

**What over the Counter Medications?**______________________________________________

**Aspirins** Yes No **What Vitamins & Supplements Are You Taking?** ______________________

. **MEDICAL HISTORY:** Do You 'Personally' Have Any History Of, Or Being Treated For Any Of The Following Conditions Below: ***Circle Yes Or No And Give Details If Yes***

G**Yes** G**No**C **Diabetes** ______________________________________________________

G**Yes** G**No**C **High Blood Pressure** ______________________________________________

G**Yes** G**No**C **Heart** Disease ______________________________ G**Yes** G**No**C Heart Murmur______________

G**Yes** G**No**C **Lung Disease**______________________________ G**Yes** G**No**C Sinusitis ______________

G**Yes** G**No**C **Stroke** Or **Neurological** Problems________________ G**Yes** G**No**C Tooth Disease______________

G**Yes** G**No**C **Any Bleeding Disorders Or Blood Diseases?** ______________________________

G**Yes** G**No**C **Constipation** Or **Intestinal** Problems________________ G**Yes** G**No**C **Ulcers**______________

G**Yes** G**No**C **Any Skin Disorders**? ____________________ G**Yes** G**No**C **Hormone Problems**______________

G**Yes** G**No**C **Glaucoma** Or Any **Eye** Problems?____________ G**Yes** G**No**C **Any History Of Hearing Disorders?** _______

G**Yes** G**No**C Any History Of **Arthritis Or Muscle Or Bone** Problems?______________________________

**Any Chronic Infections?** ______________________________________________________

**Other:** ______________________________________________________________

. **Allergies** (Medications): **Yes** **No** ______________________________________________

**Allergies** (Food): **Yes** **No** ______________________________________________