NORTH COAST UROLOGY

Medical History Questionnaire

Appointment Date: _____/_____/_____ Your Name: _____

Date of Birth: _____/_____/_____ Age: _____ Primary Care Physician: _____

Reason for your visit: _____

On a scale of 1-10, how severe is the problem? (please circle) 1 2 3 4 5 6 7 8 9 10
Approximately when did you first notice the problem? _____
How long does the problem last? _____
Is the problem constant or variable? (please circle)
Does the problem interfere with your normal function? Yes: _____ No:_____
Does anything help the problem?_____
Does anything make the problem worse? _____

Current Urinary Symptoms:

Hesitancy starting urinary stream	Yes/No	Urgency to urinate	Yes/No
Decreased force of stream	Yes/No	Burning sensation with urination	Yes/No
Interrupted stream	Yes/No	Increased frequency of urination (_____day)	Yes/No
Dribbling after urination	Yes/No	Getting up at night to urinate (_____ times)	Yes/No
Blood in urine	Yes/No	History of kidney stones	Yes/No
Sensation of incomplete bladder emptying	Yes/No		

Activities Associated with Urine Leakage

With coughing, laughing, sneezing	Yes/No	With a sudden urge to urinate	Yes/No
With activity or exercise	Yes/No	Continuous leakage without warning	Yes/No
With standing up	Yes/No	Protective pads worn (_____pads/day)	Yes/No
While sleeping	Yes/No		

Past or Present Medical Conditions (eg. diabetes, heart disease, kidney disease, cancer, arthritis, etc.)

Medical History cont.

Your Name: _____

Current Medications: (name and dosage)

Past Surgical History: (What type & approximately when)

Other Prior Hospitalizations: (When and Why?)

Allergies: Yes/No (If yes, please list allergies and type of reaction)

Social History:

Marital Status: Single Married Divorced Widow Widower		Occupation:
Do you drink alcohol?	Yes/No	How many years did you smoke?
If yes, how much?		How many packs per day?
Do you currently smoke?	Yes/No	When did you quit?
Have you smoked in the past?	Yes/No	Marijuana/Recreational drug use. Yes/No

Family History:

Relative	Medical Problems (eg: diabetes, hypertension, heart disease, cancer, stroke, etc.)	Alive	Age
Father		Yes/No	
Mother		Yes/No	
Brother		Yes/No	
Sister		Yes/No	