Golden Gate Urology, Inc.

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Medical History Form

Your name: _____
Last First Middle Initial

Date of birth: _____ Who referred you? _____

Age: _____ Primary doctor/internist: _____

Gender (circle one): Male Female Other

The pharmacy you use (Name, street, city): _____

Your height _____

Your weight _____

What is the main reason that you came to see the doctor today? _____

_____

Please answer the following questions (if not applicable, write "N/A")

Location of problem: _____

Symptom quality (e.g. sharp, dull, throb): _____

How severe is the problem? (use a scale of 0-10, 10 is worst) _____

How long have you had the problem? _____

How often does the problem occur? _____

Does it occur in certain situations? _____

Does anything make it better? _____

Does anything make it worse? _____

(Continued on next page)

Medical Problems

CIRCLE all that apply

No known medical problems
Kidney stones
Diabetes
High blood pressure (hypertension)
Elevated cholesterol
Heart murmur
Irregular heart rhythm (arrhythmia)
Previous heart attack
Clogged heart arteries (coronary disease)
Congestive heart failure (CHF)
Previous stroke
Previous blood clot in leg (DVT)
Previous blood clot in lung (PE)
Emphysema or COPD
Asthma
Underactive thyroid (hypothyroidism)
Overactive thyroid (hyperthyroidism)
Osteoporosis
Arthritis
Glaucoma
Hepatitis
HIV/Aids
Sleep apnea or snoring
Ulcer in stomach or intestines
GERD (gastroesophageal reflux)
Bleeding disorder (bleeding easily)

List any additional medical problems below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Surgeries

Have you had problems with anesthesia? Yes No
If yes, please explain:

CIRCLE all that apply

No prior surgeries
Appendectomy
Tonsillectomy
Gall bladder removal (cholecystectomy)
Hysterectomy
Groin hernia repair (inguinal hernia)
Pacemaker
Implanted defibrillator
Heart bypass (CABG)
Heart stent
Heart valve replacement
Joint replacement
Spine surgery
Cataract surgery
Vasectomy

List any additional surgeries below and the approximate year they were performed:

_____

_____

_____

_____

_____

_____

_____

Social and Family History

Do you or did you ever smoke? Yes No
If yes, how many packs per day? _____
If yes, how many years have you smoked?_____
If you quit, what year did you quit? _____
Do you currently smoke? Yes No
Are you sexually active? Yes No
Prolonged exposure to radiation? Yes No
Prolonged exposure to chemicals? Yes No
Occupation:_____
How many children do you have? _____
For a child: are immunizations up to date? Yes No

Your alcohol consumption (circle one):
Never Socially Heavy
Occasionally Daily Sober alcoholic

Marital/Relationship status (circle one):
Single Married Partnered Divorced Widowed

Family History (circle all that apply & indicate relation who has the disease, if known)
No known family history
Kidney Cancer _____
Prostate Cancer _____
Testicular Cancer _____
Infertility _____
Kidney stones _____
Bleeding disorder _____
Diabetes _____
High blood pressure _____
Other (please specify):

Medications

(Please list all prescription and non-prescription substances that you take, including medications, vitamins, and supplements. Include the doses and the frequency of use, if known)

1._____ 8._____
2._____ 9._____
3._____ 10._____
4._____ 11._____
5. _____ 12. _____
6._____ 13._____
7._____ 14._____

Allergies

(Write in the type of reaction, such as rash, itching, swelling, etc.)

CIRCLE all that apply

No known allergies
Penicillin
Sulfa
Iodine
Intravenous contrast
Latex
Shellfish

List any additional allergies (to medicine, food, or environment) below and the type of reaction:

_____
_____
_____
_____
_____
_____

Review of Body Systems and Symptoms (circle "yes" or "no" for each item)

Yes No Fevers
Yes No Chills
Yes No Sweats
Yes No Poor appetite
Yes No Fatigue
Yes No Feeling ill
Yes No Weight loss

Yes No Blurry vision
Yes No Double vision
Yes No Eye irritation
Yes No Eye discharge
Yes No Vision loss
Yes No Eye pain
Yes No Sensitivity to bright light

Yes No Ear ache
Yes No Ear discharge
Yes No Ringing in your ear (tinnitus)
Yes No Hearing loss
Yes No Nasal congestion
Yes No Nose bleeds
Yes No Sore throat
Yes No Hoarse voice
Yes No Difficulty swallowing

Yes No Breast swelling
Yes No Breast lump
Yes No Nipple discharge
Yes No Breast pain
Yes No Skin over breast is abnormal

Yes No Chest pain
Yes No Palpitations (skip heartbeat)
Yes No Loss of consciousness
Yes No Short of breath with exertion
Yes No Short of breath lying down
Yes No Wake up short of breath
Yes No Swelling in you legs/ankles

Yes No Cough
Yes No Short of breath
Yes No Lot of phlegm
Yes No Blood in phlegm
Yes No Wheezing

Yes No Nausea
Yes No Vomiting
Yes No Diarrhea
Yes No Constipation
Yes No Change in bowel habits
Yes No Abdominal pain
Yes No Blood in stool (dark color)
Yes No Blood in stool (bright color)
Yes No Yellow color to skin (jaundice)

Yes No Burn/pain with voiding
Yes No Frequent urination
Yes No Urgent urination
Yes No Get up at night to urinate
Yes No Difficulty starting stream (hesitancy)
Yes No Slow/weak urinary stream
Yes No Strain to urinate
Yes No Intermittent stream
Yes No Feels like I don't empty my bladder
Yes No Leak urine with cough/laugh/strain
Yes No Urge so strong that I leak urine
Yes No Bedwetting
Yes No Blood in urine
Yes No Kidney disease
Yes No Kidney stones
Yes No Urinary infections
Yes No Have/had a sexually transmitted disease
Yes No Pelvic pain

For Females
Yes No History of tubal ligation
Yes No Vaginal discharge
Yes No Vaginal bleeding
Yes No Pain with intercourse

For Males
Yes No History of vasectomy
Yes No Penile discharge
Yes No Testicle pain
Yes No Penile pain
Yes No Erectile dysfunction
Yes No Decreased libido (low sex drive)

Review of Body Systems (circle "yes" or "no" for each item)

Yes No Flank pain
Yes No Back pain
Yes No Joint pain
Yes No Joint swelling
Yes No Muscle cramps
Yes No Muscle weakness
Yes No Joint stiffness
Yes No Arthritis

Yes No Skin rash
Yes No Itching
Yes No Skin dryness
Yes No Skin lesions that concern you

Yes No Temporary paralysis
Yes No Weakness
Yes No Numbness, tingling, prickling sensation
Yes No Seizures
Yes No Loss of consciousness
Yes No Tremors
Yes No Vertigo (feeling as if the room is spinning despite your remaining still)

Yes No Depression
Yes No Anxiety
Yes No Memory loss
Yes No Psychiatric diagnosis
Yes No Suicidal thoughts
Yes No Hallucinations
Yes No Paranoia

Yes No Cold intolerance
Yes No Heat intolerance
Yes No Excessive eating (polyphagia)
Yes No Excessive drinking (polydipsia)
Yes No Excessive volume of urine produced (polyuria)
Yes No Weight change

Yes No Abnormal bruising
Yes No Bleed easily
Yes No Enlarged lymph nodes

Yes No Hives (raised, red, itchy rash)
Yes No Hay fever
Yes No Persistent infections
Yes No HIV exposure