SWEDISH
MEDICAL GROUP

SWEDISH UROLOGY

Patient History Form – Male

Note: This is a confidential record and will be kept as part of your chart. Information provided here will not be released to anyone without your authorization to do so.

Name:_____ Today's date: _____

Date of birth:_____ Age: _____ Social Security Number: _____

Were you referred to our office by another physician? ☐ Yes ☐ No

If yes, name: _____ Phone:_____

CURRENT PROBLEM

What is the main problem that brings you to the office today? (Describe your symptoms in detail)

_____

_____

When did you first notice the problem or symptoms?: _____

Where in your body do the symptoms arise? _____

Do they travel or go anywhere? _____

Had you experienced any similar symptoms in the past? _____

Are the symptoms continuous, variable or only occasionally present? _____

When present, how long do they last? _____

How severe are the symptoms that arise at the same time? _____

Do you notice any other symptoms that arise at the same time? _____

What seems to make the symptoms worse (activity, food, etc.)? _____

What seems to make the symptoms better? _____

Do the symptoms interfere with your normal function? _____

PAST MEDICAL HISTORY

Please list all illnesses requiring medical treatment, surgery or hospitalization:

_____

_____

_____

Please list current/recent medications: (Include dose, how often and date began)

_____

_____

_____

MEDICATION ALLERGIES (Please list reaction)

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY

Please list any major illnesses in family members, parents' age or age at death, siblings' age or age at death:

Father: _____ Mother: _____

Brothers/sisters: _____

Grandparents: _____

SOCIAL HISTORY

What is your occupation? _____

Marital status? _____

Do you live alone? _____

Number of children? _____

How much alcohol do you drink per day? _____

How much caffeine do you use per day? _____

Have you used any recreational drugs? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, years/amount: _____

Did you smoke in the past? ☐ Yes ☐ No If yes, dates: _____

(over)

MALE UROLOGIC SYMPTOMS/HISTORY

Have you had any of the following in the last six months? Please circle any that apply.

General

Y N Stones of the kidney, ureter or urinary bladder?
Y N Cancer of the kidney, ureter, bladder, testicle or prostate?
Y N Infection of the prostate, testicle, bladder or kidney?
Y N Trauma to the kidney, groin or testicle?
Y N Herpes, genital warts or gonorrhea?
Y N Surgery on kidney, bladder, prostate or vasectomy?
Y N PSA (most recent _____)?
Y N Fevers
Y N Chills
Y N Sweats
Y N Anorexia
Y N Fatigue
Y N Malaise
Y N Weight loss

Eyes

Y N Blurring
Y N Double vision
Y N Irritation
Y N Discharge
Y N Vision loss
Y N Eye pain
Y N Light sensitivity

Ears/Nose/Throat

Y N Earache
Y N Ear discharge
Y N Ringing
Y N Hearing loss
Y N Nasal congestion
Y N Nosebleeds
Y N Sore throat
Y N Hoarseness
Y N Painful swallowing

Cardiovascular

Y N Chest pains
Y N Palpitations
Y N Dizziness/syncope
Y N Shortness of breath
Y N Shortness of breath lying down
Y N Sudden nighttime breathlessness
Y N Ankle swelling

Respiratory

Y N Cough
Y N Shortness of breath
Y N Excessive sputum
Y N Bloody sputum
Y N Wheezing

Gastrointestinal

Y N Nausea
Y N Vomiting
Y N Diarrhea
Y N Constipation
Y N Change in bowel habits
Y N Abdominal pain
Y N Black or tarry stools
Y N Red blood in the stools
Y N Jaundice

Genitourinary

Y N Getting up at night to urinate
Y N Frequent urination
Y N Urgent need to urinate
Y N Urethral pain on voiding
Y N Difficulty starting stream
Y N Slowing of urine stream
Y N Intermittent urine stream
Y N Feeling bladder doesn't empty completely
Y N Incontinence
Y N Blood in the urine
Y N Urethral discharge
Y N Testicular pain
Y N Difficulty with erections
Y N Decreased libido
Y N Vasectomy

Musculoskeletal

Y N Back pain
Y N Joint pain
Y N Joint swelling
Y N Muscle cramps
Y N Muscle weakness
Y N Stiffness
Y N Arthritis

Skin

Y N Rash
Y N Itching
Y N Dryness
Y N Suspicious lesions

Neurologic

Y N Transient paralysis
Y N Weakness
Y N Tingling numbness
Y N Seizures
Y N Dizziness
Y N Tremors
Y N Room spinning

Psychiatric

Y N Depression
Y N Anxiety
Y N Memory loss
Y N Mental disturbance
Y N Thoughts of suicide
Y N Hallucinations
Y N Paranoia

Endocrine

Y N Cold intolerance
Y N Heat intolerance
Y N Constant thirst
Y N Constant hunger
Y N Frequent urination
Y N Weight gain

Heme/Lymphatic

Y N Abnormal bruising
Y N Bleeding
Y N Low blood count
Y N Enlarged lymph nodes

Allergic/Immunologic

Y N Hives
Y N Hay fever
Y N Persistent infections
Y N HIV exposure