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BASS MEDICAL GROUP

PATIENT HISTORY FORM (MALE)

DATE _____/_____/_____

NAME _____ PRIMARY CARE DOCTOR _____

REASON FOR VISIT _____

PAST MEDICAL HISTORY

Please check whether you have or have had any of the following conditions:

Diabetes	☐ Yes	☐ No	High cholesterol	☐ Yes	☐ No
High blood pressure/Hypertension	☐ Yes	☐ No	COPD/emphysema	☐ Yes	☐ No
Coronary artery disease	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Chronic renal failure	☐ Yes	☐ No	Dementia (e.g., Alzheimer's)	☐ Yes	☐ No
Atrial fibrillation	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No
Type _____			Hepatitis C	☐ Yes	☐ No
Type _____			HIV	☐ Yes	☐ No

Others:

PAST SURGICAL HISTORY

Please list all prior surgeries:

Surgery	Year	Surgery	Year

MEDICATIONS

Please list all current medications, including vitamins:

Name of medication	Dose	Frequency

ALLERGIES

Please list all drug allergies:

Drug	Reaction

SEE ATTACHED ☐

Reviewed by MD & discussed with patient _____

UROLOGIC HISTORY

Kidney stones

Have you ever had kidney stones? (***If no, skip to next section.***) ☐ Yes ☐ No
How many? Right: _____ Left: _____
When was your most recent stone? _____
Have you ever needed a surgical procedure for stones? ☐ Yes ☐ No
☐ ESWL (shock lithotripsy)
☐ Ureteroscopy
☐ PCNL (percutaneous lithotripsy – through a hole in the back)
☐ Open stone surgery (flank or abdominal incision)

Infections

Have you ever had a urinary tract infection (UTI)? (***If no, skip to next section.***) ☐ Yes ☐ No
How old were you when you had your first UTI? _____
When was your last UTI? _____
On average, how many UTIs do you get per year? _____

Have you ever had a kidney infection? ☐ Yes ☐ No
If so, which side? ☐ Right ☐ Left ☐ Both

What are your typical UTI symptoms? (check all that apply)
☐ Fever ☐ Burning ☐ Frequency ☐ Urgency (gotta go now!) ☐ Suprapubic pain ☐ Flank pain
☐ Foul smell ☐ Other: _____

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No
If so, what type? _____ ☐ Yes ☐ No

Urinary symptoms

How often do you urinate during the day? Every _____ hours
How often do you get up to urinate at night? _____
Does it burn or sting when you urinate? ☐ Yes ☐ No
Do experience "urgency" (the need to go *right away*)? ☐ Yes ☐ No

Do you find it difficult to *start* urinating? ☐ Yes ☐ No
Do you have to push or strain to urinate? ☐ Yes ☐ No
Do you feel that you have a weak stream? ☐ Yes ☐ No
Does your urination start and stop? ☐ Yes ☐ No
Do you dribble urine after you finish? ☐ Yes ☐ No
Do you feel that you are unable to empty your bladder completely? ☐ Yes ☐ No
Have you ever needed to be catheterized because you couldn't urinate? ☐ Yes ☐ No
Has your urethra ever been stretched or dilated? ☐ Yes ☐ No
Do you ever leak urine? ☐ Yes ☐ No

Have you ever seen blood in the urine? ☐ Yes ☐ No
Have you recently seen blood in the urine? ☐ Yes ☐ No

Reviewed by MD & discussed with patient _____

FAMILY HISTORY			
Please answer the following questions about your family members:			
Father	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Mother	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Siblings	# of brothers _____ # of sisters _____		
	Please list their medical problems (if any):		
Children	# of sons _____ # of daughters _____ Please list their medical problems (if any):		
Other	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)		

Has anyone in your family had prostate cancer? ☐ Yes ☐ No
If yes, please list their relationship to you and their age at diagnosis:

Has any family member had any disorder of the kidneys, bladder, or other part of the urinary tract? ☐ Yes ☐ No
If yes, please describe:

SOCIAL HISTORY		
Personal	Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
	Religious affiliation, if any?	Primary language?
Alcohol	Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week?	
	☐ Beer ☐ Wine ☐ Liquor	
Tobacco	Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?	
	What year did you start?	What year did you quit?
Drugs	Do you currently use recreational drugs? ☐ Yes ☐ No Have you in the past? ☐ Yes ☐ No	
	If yes, what kind?	
	Have you ever used intravenous drugs? ☐ Yes ☐ No	
Employment	Employment status: ☐ Employed ☐ Unemployed ☐ Retired	
	Occupation (past or present):	
Miscellaneous	Have you ever received a blood transfusion? ☐ Yes ☐ No	

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REVIEW OF SYSTEMS

Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:

Constitutional
- Fever ☐ Yes ☐ No
- Headache ☐ Yes ☐ No
- Unexplained weight loss ☐ Yes ☐ No
- Other:_____

Neurologic
- Numbness ☐ Yes ☐ No
- Tingling ☐ Yes ☐ No
- Weakness ☐ Yes ☐ No
- Dizziness ☐ Yes ☐ No
- Memory loss ☐ Yes ☐ No
- Seizures ☐ Yes ☐ No
- Other: _____

Respiratory
- Shortness of breath ☐ Yes ☐ No
- Wheezing ☐ Yes ☐ No
- Cough ☐ Yes ☐ No
- Other: _____

Cardiovascular
- Chest pain ☐ Yes ☐ No
- Irregular pulse ☐ Yes ☐ No
- Other: _____ _____

Gastrointestinal
- Abdominal pain ☐ Yes ☐ No
- Nausea/vomiting ☐ Yes ☐ No
- Indigestion/heartburn ☐ Yes ☐ No
- Diarrhea ☐ Yes ☐ No
- Constipation ☐ Yes ☐ No
- Other: _____

Eyes
- Blurred vision ☐ Yes ☐ No
- Glaucoma ☐ Yes ☐ No
- Other: _____

Ear/Nose/Throat/Mouth
- Runny nose ☐ Yes ☐ No
- Difficulty hearing ☐ Yes ☐ No
- Other: _____

Endocrine
- Excessive thirst ☐ Yes ☐ No
- Too hot ☐ Yes ☐ No
- Too cold ☐ Yes ☐ No
- Other: _____

Allergic/Immunologic
- Hay fever ☐ Yes ☐ No
- Food allergies ☐ Yes ☐ No
- Other:_____

Musculoskeletal
- Joint pain ☐ Yes ☐ No
- Back pain ☐ Yes ☐ No
- Artificial joints ☐ Yes ☐ No
- Other: _____

Hematologic/Lymphatic
- Easy bruising or bleeding ☐ Yes ☐ No
- Blood clots in arms or legs ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Other: _____

Psychologic
- Anxiety ☐ Yes ☐ No
- Depression ☐ Yes ☐ No
- Other: _____

Integumentary
- Rash ☐ Yes ☐ No
- Boils/infections ☐ Yes ☐ No
- Other: _____

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AUA SYMPTOM INDEX (circle the number that best applies)						
	Never	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost always**
1. Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
2. Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
3. Over the past month or so, how often have you found you stopped and started again several times when you urinated?	**0**	**1**	**2**	**3**	**4**	**5**
4. Over the past month or so, how often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**
5. Over the past month or so, how often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**
6. Over the past month or so, how often have you had to push or strain to begin urination?	**0**	**1**	**2**	**3**	**4**	**5**
7. Over the last month, how many times did you usually get up to urinate from the time you went to bed at night until the time you got up in the morning?	**0**	**1**	**2**	**3**	**4**	**5 or more**
AUA SCORE (add all items) _____						
How much do your urinary symptoms bother you? ☐ Not at all ☐ A little ☐ Somewhat ☐ A lot Do you want treatment (or a different treatment) for your urinary symptoms? ☐ Yes ☐ No						

International Index of Erectile Function (circle the answer that best applies) (OPTIONAL)					
Over the past 6 months:	**1**	**2**	**3**	**4**	**5**
1. How do you rate your confidence that you could get and keep an erection?	Very low	Low	Moderate	High	Very High
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	Almost never or never	Much less than half the time	About half the time	Much more than half the time	Almost always or always
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Almost never or never	Much less than half the time	About half the time	Much more than half the time	Almost always or always
4. During sexual intercourse how difficult was it to maintain your erection to the completion of intercourse?	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never or never	Much less than half the time	About half the time	Much more than half the time	Almost always or always
IIEF SCORE (add all items) _____					
Do you want treatment (or a different treatment) for erectile dysfunction? ☐ Yes ☐ No					

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