

**ADULT MALE HISTORY FORM
UROLOGIC SPECIALISTS OF OKLAHOMA, INC.**

Revised December 2009-UC

Please complete all sections

PLEASE LIST ALL DRUG ALLERGIES

Latex Rubber: Yes No Unknown
 Shellfish: Yes No Unknown
 X-Ray Dye: Yes No Unknown
 Past problems w/ Anesthesia Yes No Unk
 Past transfusion reactions Yes No Unk

DATE:

PATIENT NAME:
DOB:
PRIMARY PHYSICIAN:
REFERRING PHYSICIAN:

MEDICATIONS Yes No **REVIEW OF SYSTEMS**

Please list all medications you currently use: (including over the counter drugs i.e. aspirin)				Yes	No	GENERAL SYMPTOMS
Name	Dose	Frequency	Last Dose			Fever
						Recent weight loss/gain
						CARDIOVASCULAR (HEART)
						Irregular Heart Beat
						Chest Pain
						Heart Attack (s)
						Mitral Valve Prolapse or Heart Murmur
						High Blood Pressure
						RESPIRATORY
						Shortness of Breath

ADULT MALE GENITOURINARY HISTORY Yes No **WHEN?**

YES	NO		WHEN?	Yes	No	
		Burning when urinating				Emphysema
		Discharge from Penis				Cough
						GASTROINTESTINAL
		Blood in Urine				Abdominal Pain
		Difficulty in starting to urinate				Stomach Ulcers
		Slow Stream				Hiatal Hernia/Reflux
		Interruption of the stream				Jaundice
		Difficulty emptying the bladder				Nausea
		Pain in your kidneys				MUSCULOSKELETAL
		Urinary Tract Stones				Arthritis

How frequently do you urinate during the day?

How frequently do you urinate during the night?

Do you have any problems with sexual functioning? YES NO

Explain:

SURGERY/HOSPITALIZATION HISTORY Yes No **ENDOCRINE**

(LIST ALL OPERATIONS/PROCEDURES WITH DATES)

	Yes	No	Thyroid Disease
			Diabetes
			BLOOD DISORDERS
			Anemia
			Bleeding Tendencies
			CANCER
			Bladder
			Prostate

MEDICAL HISTORY (LIST ALL HEALTH PROBLEMS)

			Kidney
			Other:

FAMILY HISTORY Yes No **FAMILY HISTORY**

Has anyone in your family had?

			Bladder Cancer
			Prostate Cancer
			Kidney Cancer
			Other Cancer?

FAMILY HISTORY (INCLUDE DIAGNOSIS & RELATIONSHIP)

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SOCIAL HISTORY BP: RESP: HR: PULSE: TEMP:

WHAT CITY DO YOU LIVE IN? OCCUPATION?

MARITAL STATUS:

DO YOU USE TOBACCO? YES NO HOW MUCH?

DO YOU DRINK ALCOHOL? YES NO HOW MUCH?

HOW MANY CAFFIENE DRINKS PER DAY?

HAVE YOU HAD A BLOOD TRANSFUSION?

DESCRIBE YOUR PROBLEM:
