ADVANCED UROLOGY
CENTERS OF NEW YORK
A Division of Integrated Medical Professionals, PLLC

Male Patient History Form

First Name:_____ Last Name:_____

Date of Birth:_____ Today's Date:_____

History of Present Illness

Reason for today's visit: _____
How long has this problem been occurring? ____days; ____weeks; ____ months; ____years
Does anything make the problem better? _____
Does anything make the problem worse? _____
Does the problem come and go or is it always there?_____
If there is pain, where is the pain located? _____
If there is pain, describe the pain: _____
If there is pain, on a scale of 1-10 (10 being most severe), describe the severity of the pain: _____

Review of Systems—Indicate if you are experiencing or have recently experienced any of the following:

General			Digestive		
Chills	☐Yes	☐No	Abdominal pain	☐Yes	☐No
Fever	☐Yes	☐No	Constipation	☐Yes	☐No
Fatigue	☐Yes	☐No	Nausea/Vomiting	☐Yes	☐No
Skin			**Musculoskeletal**		
Bruising	☐Yes	☐No	Back pain	☐Yes	☐No
Itching	☐Yes	☐No	Joint pain	☐Yes	☐No
Rash	☐Yes	☐No	Muscle pain	☐Yes	☐No
Head and Neck			**Neurological**		
Headache	☐Yes	☐No	Dizziness	☐Yes	☐No
Ringing in the ear	☐Yes	☐No	Seizures	☐Yes	☐No
Nasal congestion	☐Yes	☐No	Weakness	☐Yes	☐No
Lungs			**Endocrine**		
Shortness of breath	☐Yes	☐No	Appetite changes	☐Yes	☐No
Cough	☐Yes	☐No	Excessive thirst	☐Yes	☐No
Wheezing	☐Yes	☐No			
Cardiovascular			**Hematology**		
Chest pains	☐Yes	☐No	Blood clots	☐Yes	☐No
Palpitations	☐Yes	☐No	Enlarged lymph nodes	☐Yes	☐No
			Prolonged bleeding	☐Yes	☐No

Male Genitourinary—Indicate if you are experiencing or have recently experienced any of the following:

Blood in urine	☐Yes	☐No	Painful urination	☐Yes	☐No
Change in urinary stream	☐Yes	☐No	Penile lesions	☐Yes	☐No
Flank pain	☐Yes	☐No	Testicular mass	☐Yes	☐No
Frequency	☐Yes	☐No	Testicular pain	☐Yes	☐No
Hesitancy	☐Yes	☐No	Urethral discharge	☐Yes	☐No
Impotence	☐Yes	☐No	Urgency	☐Yes	☐No
Inability to hold urine	☐Yes	☐No	Urinating at night	☐Yes	☐No
Incomplete bladder emptying	☐Yes	☐No			

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Name:_____ Date of Birth:_____

International Prostate Symptoms Score (IPSS)						
Questions	**Not at all**	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost always**
Over the past month, how often have you had the sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5
Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
Over the past month, how often have you found you stopped and started again when you urinated?	0	1	2	3	4	5
Over the past month, how often did you find it difficult to postpone urination?	0	1	2	3	4	5
Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
Over the past month, How often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 or more Times
Over the past month, how many times did you most typically 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
Total IPSS Score: Sum of seven circled number (IPSS) Mild: 0-7 Moderate: 8-19 Severe: 20-35 Score:_____						

Quality of Life Due to Urinary Symptoms	**Delighted**	**Pleased**	**Mostly Satisfied**	**Mixed**	**Mostly Dissatisfied**	**Unhappy**	**Terrible**
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

Past Medical History— Have you ever had or do you currently have any of the following?

Anemia ☐	Crohn's Disease ☐	High Blood Pressure ☐
Arthritis ☐	Depression ☐	High Cholesterol ☐
Asthma ☐	Diabetes ☐	HIV/AIDS ☐
Atrial Fibrillation ☐	Diverticulitis ☐	Kidney stones ☐
Back problems ☐	GERD ☐	Prostatitis ☐
Bleeding disorder ☐	Irritable Bowel Syndrome ☐	Renal Insufficiency ☐
Cancer ☐	Heart Attack ☐	Sleep Apnea ☐
Congestive Heart Failure ☐	Hemorrhoids ☐	Stroke ☐
Coronary Artery Disease ☐	Hepatitis ☐	Thyroid disease ☐
COPD ☐	Hernia ☐	

Clarify any checked answers above which require explanation (ie: type of Cancer):_____

_____

_____

List any Medical History not mentioned above: _____

_____

_____

_____

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Name:_____ Date of Birth:_____

Allergies:

☐ No Known Allergies ☐ No Known Drug Allergies

List allergies to Medications, Food, etc: _____
_____
_____

Do you have reactions to iodine?	☐Yes	☐No
Do you have reactions to seafood?	☐Yes	☐No
Do you have reactions to x-ray dye?	☐Yes	☐No

Family History:

Problem	Father	Mother	Sibling	Other
Bladder Cancer	☐	☐	☐	☐
Kidney Cancer	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐
Testicular Cancer	☐	☐	☐	☐
Other Cancer - Specify:_____	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐

Social History:

Do you currently smoke?	☐Yes	☐No	If yes, how much?_____	If yes, how long?____
Are you a former smoker?	☐Yes	☐No	If yes, what year did you start?_____	What year did you quit? _____
Do you drink alcohol?	☐Yes	☐No	If yes, how much?_____	How often?_____
Do you or have you ever used drugs?	☐Yes	☐No		

Medications—Please list all medications, including vitamins, herbs, supplements, and over the counter:

Name	Amount	Times per day	Name	Amount	Times per day

Have you ever been told that you need to take antibiotics before dental procedures? ☐Yes ☐No

Surgical History—List all surgeries and dates; include side of the body (ie: left knee surgery):

_____
_____

Diagnostic Studies/Health Maintenance:	**Vital signs:**
Last PSA: _____	Current Height: ____' ____"
Last Colonoscopy: _____	Current Weight: _____lbs.