HEALTH HISTORY/INFORMATION 4/3/2014

Name_____ Date of Birth_____
Primary Care Physician_____ Weight_____
Phone Number (PCP)_____ Height_____
Local Pharmacy_____ Referred BY:
Pharmacy Phone Number_____ _____

CHIEF COMPLAINT (Why you are here to see our physician) Female ☐ Male ☐

MEDICAL HISTORY	**Yes**	**No**
Diabetes……..	☐	☐
High Blood Pressure…..	☐	☐
Cancer……..	☐	☐
Stroke……..	☐	☐
Heart Attack……..	☐	☐
Bleeding Tendency….....	☐	☐
Venereal Disease…….	☐	☐
Hereditary Defects…….	☐	☐
Thyroid Disease……	☐	☐
Vasectomy……..	☐	☐
Tubal Ligation……..	☐	☐

Other_____

PREVIOUS SURGERIES/HOSPITALIZATIONS/INJURIES

_____Date_____
_____Date_____
_____Date_____
_____Date_____

ALLERGIES	**YES**	**NO**	**TYPE OF REACTION**
Shellfish……..	☐	☐	_____
Iodine…….	☐	☐	_____
Latex……..	☐	☐	_____

Other…….._____
Medication Allergies_____
_____
_____

SOCIAL HISTORY

Marital Status:
Single ☐
Married ☐
Divorced ☐
Widowed ☐

Use of Alcohol:
Never ☐
Rarely ☐
Moderate ☐
Daily ☐

Use of Tobacco:
Never ☐
Previously, but quit ☐
Currently ☐
Packs per day_____

Use of Drugs:
Never ☐
Currently ☐
Type_____
Frequency_____

Excessive exposure at home or work to Fumes?
Yes ☐ No ☐

FAMILY MEDICAL HISTORY

	Age	**Deceased**	**Diseases**	**If Deceased, Cause of Death**
Father	_____	☐	_____	_____
Mother	_____	☐	_____	_____
Siblings	_____	☐	_____	_____
	_____	☐	_____	_____
	_____	☐	_____	_____
Spouse	_____	☐	_____	_____
Children	_____	☐	_____	_____
	_____	☐	_____	_____
	_____	☐	_____	_____

REVIEW OF SYSTEMS

CONSTITUTION SYMPTOM	Yes	No
You've had good general health lately…..	☐	☐
Recent weight change……	☐	☐
Fever……..	☐	☐
Fatigue……..	☐	☐
Headaches……..	☐	☐

EYES	Yes	No
Wear glasses……	☐	☐
Blurred or double vision……..	☐	☐
Glaucoma……	☐	☐

CARDIOVASCULAR	Yes	No
Chest pain or angina pectoris…….	☐	☐
Palpitation……	☐	☐
Swelling of feet ……..	☐	☐
Swelling of ankle…….	☐	☐
Swelling of hand…….	☐	☐

RESPIRATORY	Yes	No
Chronic frequent coughs……	☐	☐
Shortness of breath……	☐	☐
Asthma or wheezing…….	☐	☐

GASTROINTESTINAL	Yes	No
Loss of appetite……..	☐	☐
Change in bowel movements……..	☐	☐
Nausea or vomiting…….	☐	☐
Frequent diarrhea……..	☐	☐
Painful bowel movements or Constipation……	☐	☐
Rectal bleeding or blood in stool……..	☐	☐
Abdominal pain or Heartburn…….	☐	☐
Peptic ulcer (stomach or duodenal)…….	☐	☐

Female:	Yes	No
Pain with periods…….	☐	☐
Irregular periods……..	☐	☐
Vaginal discharge……	☐	☐

Date of Last menstrual cycle_____

Date of Last pap smear_____

# of Pregnancies _____ # of Vaginal deliveries_____ # of C-sections_____ # of Miscarriages_____

MUSCULOSKELETAL	Yes	No
Joint Pain……	☐	☐
Back Pain……	☐	☐
Difficulty walking…….	☐	☐

NEUROLOGICAL	Yes	No
Frequent recurring headaches…	☐	☐
Convulsions or Seizures…….	☐	☐
Head Injury……	☐	☐

PSYCHIATRIC	Yes	No
Memory loss or confusion……..	☐	☐
Nervousness……..	☐	☐
Depression……..	☐	☐

ENDOCRINE	Yes	No
Thyroid disease……..	☐	☐
Excessive thirst or urination……..	☐	☐

HEMATOLOGIC/LYMPHATIC	Yes	No
Slow to heal after cuts……..	☐	☐
Anemia……	☐	☐
Past transfusion……	☐	☐

GENITOURINARY	Yes	No
Frequent urination……	☐	☐
Burning or painful urination……..	☐	☐
Blood in urine……	☐	☐
Change in force or strain when urinating……..	☐	☐
Incontinence or dribbling……..	☐	☐
Kidney Stones……	☐	☐
Sexual difficulty……..	☐	☐

CURRENT MEDICATIONS

_____

_____

_____

_____

**LIST ADDITIONAL MEDS ON BACK OF SHEET

Male:	Yes	No
Testicle pain……	☐	☐

Name_____

Date of Birth_____

Take this quiz below to see if you may be experiencing Erectile Dysfunction (ED). Answer each question by circling the appropriate number with a response that best describes your own situation. Please be sure to select only one response for each question.

Over the past 6 months:

1. How do you rate your confidence that you can get and keep an erection?

1	2	3	4	5
Very Low	Low	Moderate	High	Very High

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

0	1	2	3	4	5
No Sexual Activity	Almost Never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (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?

0	1	2	3	4	5
Did not attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost or always

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

0	1	2	3	4	5
Did not attempt intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you?

0	1	2	3	4	5
Did not attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost or always

6. Are you satisfied with your current ED medication? Yes No

7. If you are taking ED medication, what medication are you taking?_____

Total your score for questions 1 – 5:_____

Are you a man over 50?
YOUR HEALTH CARE PROFESSIONAL WANTS YOU TO TAKE THIS TEST!

You may feel embarrassed to talk to your health care professional about urinary problems. But, like gray and thinning hair, such problems are a part of aging. One of the causes of urinary symptoms in men over 50 is a treatable condition called benign prostatic hyperplasia (BPH). In fact, it has been estimated that by the age of 80, one in every four males in the U.S. will require treatment of their urinary symptoms caused by BPH. (1)

Take this quiz to help you and your health care professional decide whether you could benefit from a BPH treatment.

Patient Name: _____ **Date:** _____ **Patient Date of Birth:** _____

TAKING THE QUIZ

Please circle the answer that best represents your response to each of the following questions. The questions are designed to gauge the severity of any symptoms you may be experiencing.

	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
1. INCOMPLETE EMPTYING Over the past month, how often have you had a sensation of not emptying your bladder completely after you have finished urinating?	0	1	2	3	4	5
2. FREQUENCY Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?	0	1	2	3	4	5
3. INTERMITTENCY Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. URGENCY Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. WEAK STREAM Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. STRAINING Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. NOCTURIA 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?	None	1 time	2 times	3 times	4 times	5 or more times
	TOTAL _____					

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
QUALITY OF LIFE DUE TO URINARY SYMPTOMS If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

SCORING THE QUIZ

Add the numbers from your answers to questions 1 through 7. The maximum possible score is 35. The final question will help you judge how you feel about your symptoms.

PLEASE NOTE: This test is used to measure the severity of your symptoms. It is not a diagnostic test. In other words, it will not tell you whether or not you have BPH. Talk to your health care professional to determine whether your symptoms are due to BPH.

Remember: This information is not intended as a substitute for medical treatment.

Reference: 1. McConnell JD, Barry MJ, Bruskewitz RC, et al. *Benign Prostatic Hyperplasia: Diagnosis and Treatment. Clinical Practice Guideline, Number 8.* AHCPR Publication No. 94-0582. Rockville, Md: Agency for health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services, February 1994.
Adapted from Barry MJ, et al. The American Urological Association Symptom Index for benign prostatic hyperplasia. J Urol. 1992;148:1549-1557.

Reference: 1. McConnell JD, Barry MJ, Bruskewitz RC, et al. *Benign Prostatic Hyperplasia: Diagnosis and Treatment. Clinical Practice Guideline, Number 8.* AHCPR Publication No. 94–0582. Rockville, Md: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. February 1994.