Craig Rinder, MD
Comprehensive Medical History for Urology Patients

Your name: _____ Date of birth: _____
Physician who referred you: _____
Your primary health care provider: _____
Name of person completing this form (if other than patient):_____

Present Illness: Describe in your own words your reason for coming to see the doctor today.
_____
_____

How long have you had this problem? _____

How severe is it? _____ Have you ever had this problem before? _____

Is this problem always there? _____

What makes your symptoms worse? _____

What makes you symptoms better? _____

Is there anything else seems to be related to your main problem? _____

Is there something else you would like to discuss? _____

Past Medical History: Please list all medical conditions, past and present, for which you have been under the care of a physician._____

_____

_____
_____
Please list all surgical procedures and operations that you have had, including dates.
_____

_____

_____

_____
Have you ever had an infection of the kidneys, bladder or urinary tract? _____ , sexually transmitted disease?

_____ , kidney stones? _____ , diabetes? _____,

heart disease? _____, stroke? _____.
Female patients: How many times have you been pregnant? _____How many children have you had? _____
Were there any problems with any of your pregnancies? _____

Children: Are all immunizations up to date? _____ Have there been any problems relating to birth, growth or development? _____ Is toilet training complete?_____ At what age? _____

Medications: List all medications you are currently taking, including aspirin, non-prescription medications and herbal or homeopathic products.

Name of medication	**Dose**	**Reason for taking**

Allergies: List all medications to which you have had a reaction in the past, allergic or otherwise.

Name of medication	**Type of reaction**

Family History: Please list any medical problems that run in your family, including birth defects, high blood pressure, heart disease, diabetes and cancer (list specific types, if known.). _____

_____

Are your parents living? _____ What are their ages (or age at death, if deceased)? _____

What medical problems has your mother had? _____

What medical problems has your father had? _____

Social History: Occupation: _____ Marital status: _____ Do you live alone? _____

Have you ever used tobacco? _____ If so, what type? _____ How much? _____ For how many years? _____

Do you drink alcohol? _____ If so, how much? _____ Have you ever had a problem with alcoholism? _____

How much coffee do you drink? _____ tea? _____ water? _____ soda? _____ What kind of soda? _____

Review of Systems: In the past 6 months, have you experienced any of the following? Please explain any **yes** answers in the space to the right of each column.

Constitutional Symptoms
Fever
Chills
Sweats
Weight change more than 10 lbs.
Loss of appetite

Eyes
Blurred vision
Double vision
Eye pain
Other

Ear, Nose, Throat, Mouth
Loss of hearing
Ear pain
Sore throat
Sinus problems
Other

Respiratory
Cough
Shortness of breath
Wheezing
Other

Cardiovascular
Chest pain or pressure
Leg pain with exercise
Varicose veins
Other

Gastrointestinal
Abdominal pain
Nausea or vomiting
Constipation
Diarrhea
Other

Immunologic
Allergies
Frequent or recurrent infections
Other

Neurologic
Headaches
Weakness
Numbness or tingling
Fainting or loss of consciousness
Tremor
Other

Genitourinary
Painful urination
Blood in the urine
Difficulty starting urination
Slow urine stream
Urinary frequency
Urgency
Do you wake at night to urinate? _____ How many times? _____
Straining to urinate
Incontinence/leakage of urine
Inability to empty the bladder
Adult male patients:
Difficulty with erections
Pain during or after sex
Other problems with sexual function
Infertility
Adult female patients:
Abnormal vaginal bleeding
Vaginal discharge
Infertility
Painful intercourse
Other sexual dysfunction

Endocrine
Excessive thirst
Excessive hunger
Heat intolerance
Cold intolerance
Severe fatigue

Integumentary
Skin rash
Persistent itch
Boils or other skin infections
Other

Musculoskeletal
Pain or stiffness of the back, neck or joints
Bone pain
Muscle pain
Other

Lymphatic/hematologic
Unusual lumps or masses
Abnormal bleeding or bruising
Blood clots

Psychiatric
Depression
Substance abuse
Other

To the best of my knowledge, the answers I have given on this form are true and complete.

Signature: _____ Date: _____