marinhealth Medical Network | UCSF Health

UROLOGY

# Health History – MALE

| REASON FOR YOUR VISIT | |
|---|---|
| | |
| | |
| **PRIOR EVALUATION BY UROLOGIST? (when, reason, and by whom)** | |
| | |

**MEDICAL HISTORY** **(Please check all that apply and note how long the problem has existed)**

| | | |
|---|---|---|
| ☐ Abnormal heart rhythm / Atrial fibrillation | ☐ Esophageal reflux | ☐ Multiple sclerosis |
| ☐ Anemia (Low blood count) | ☐ Glaucoma | ☐ Parkinson's Disease |
| ☐ Arthritis | ☐ Gout | ☐ Sexually transmitted disease: _____ |
| ☐ Asthma / emphysema / COPD | ☐ Heart attack / coronary artery disease | ☐ Stroke / TIA |
| ☐ Autoimmune or connective tissue | ☐ Heart failure | ☐ Thyroid disease |
| ☐ Bleeding / clotting disorders | ☐ High blood pressure | ☐ Tuberculosis |
| ☐ Blood clots in the legs or lungs | ☐ High cholesterol | ☐ Peptic ulcer disease |
| ☐ Cancer: _____ | ☐ Hepatitis | ☐ Urinary tract infections |
| ☐ Colitis or inflammatory bowel disease | ☐ HIV infection / AIDS | ☐ Other: _____ |
| ☐ Depression or anxiety | ☐ Infertility | ☐ Other: _____ |
| ☐ Diabetes | ☐ Kidney disease / Renal failure | ☐ Other: _____ |
| ☐ Diverticulosis or Diverticulitis | ☐ Kidney stones / Bladder stones | ☐ Other: _____ |

**SURGICAL HISTORY** **(Please check all that apply and circle the specific associated procedures, include dates)**

| | | |
|---|---|---|
| ☐ Appendectomy | ☐ Gallbladder removal: open vs laparosc | ☐ Prostate surgery: TURP |
| ☐ Bladder tumor removal (Transurethral) | ☐ Hernia repair: inguinal, umbilical | ☐ Prostate removal: open / robotic |
| ☐ Bladder removal (Total Cystectomy) | ☐ Joint surgery: _____ | ☐ Vasectomy |
| ☐ Coronary stent or bypass (CABG) | ☐ Kidney stone surgery: _____ | ☐ Other: _____ |
| ☐ Colon surgery (Colectomy) | ☐ Kidney surgery: total or partial removal | ☐ Other: _____ |
| ☐ Eye surgery: _____ | ☐ Pacemaker placement | ☐ Other: _____ |

**FAMILY HISTORY** **Please note relation (parent, sibling, or offspring)**

| | | |
|---|---|---|
| ☐ Abnormal bleeding/bruising: _____ | ☐ Prostate cancer:_____ | ☐ Breast cancer: _____ |
| ☐ Genetic diseases: _____ | ☐ Kidney cancer: _____ | ☐ Problems with anesthesia: _____ |
| ☐ Kidney stones: _____ | ☐ Bladder cancer: _____ | ☐ Other: _____ |

## SOCIAL HISTORY / HEALTH HABITS

| Marital Status<br>Single Mar Wid Div Sep | Whom do you live with? | Are you currently sexually active? |
|---|---|---|

SMOKING STATUS ☐ Current ☐ Former ☐ Never a Smoker

☐ _____ packs/day ☐ How many years? _____ ☐ Quit _____ yrs ago

ALCOHOL USE : ☐ No ☐ Yes: How many drinks / wk?

CAFFEINE USE : ☐ No ☐ Yes: How many drinks / day?

CURRENT OR FORMER OCCUPATION:

## REVIEW OF SYSTEMS Please check any symptoms that you have had in the last 6 months

### GENERAL
- ☐ Fevers
- ☐ Chills
- ☐ Weight loss
- ☐ Poor appetite
- ☐ Fatigue

### EENT
- ☐ Dry eyes
- ☐ Dry mouth
- ☐ Hearing loss
- ☐ Recent vision changes

### CARDIOVASCULAR
- ☐ Racing heart or palpitations
- ☐ Chest pain
- ☐ Calf pain with exercise
- ☐ Swelling of legs

**Can you walk > 2 blocks or 2 stair flights without shortness of breath? ☐ Yes ☐ No**

### RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

### GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Changes in bowel habits
- ☐ Blood in the stools
- ☐ Heartburn

### GENITOURINARY
- ☐ Blood in the urine
- ☐ Burning with urination
- ☐ Leakage of urine
- ☐ Flank / kidney pain
- ☐ Penile curvature

### MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Back pain
- ☐ Bone pain
- ☐ Muscle pain
- ☐ Decreased muscle mass
- ☐ Sciatica

### SKIN
- ☐ Loss of hair
- ☐ Easy bruising

### NEUROLOGICAL
- ☐ Tremor
- ☐ Dizziness
- ☐ Numbness in body part
- ☐ Headaches
- ☐ Incoordination
- ☐ Tingling / Pins and needles
- ☐ Paralysis

### PSYCHOSOCIAL
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Anxiety
- ☐ Difficulty sleeping
- ☐ Excessively high stress
- ☐ Memory problems
- ☐ Psychiatric care

### LYMPHATIC / ENDOCRINE
- ☐ Lymph node tenderness
- ☐ Swollen glands
- ☐ Excessive thirst
- ☐ Intolerance to hot / cold
- ☐ Lack of energy or strength
- ☐ Decreased libido
- ☐ Increased body fat
- ☐ Hot flashes
- ☐ Loss of height (non-age related)

**ANY KNOWN DRUG ALLERGIES? If so, please list drug and type of reaction it caused (rash, swelling, difficulty breathing, etc)**

**ANY ALLERGY TO LATEX (RUBBER PRODUCTS)? ☐ No ☐ Yes - Describe: _____**

**ANY ALLERGY TO SHELLFISH OR "IODINE DYE" (for X-ray studies)? ☐ No ☐ Yes - Describe: _____**

**CURRENT MEDICATIONS Please include prescriptions, vitamins, supplements, and over-the-counter medication ☐ NONE**

## AMERICAN UROLOGICAL ASSOCIATION SYMPTOM SCORE

| Please answer the following questions relating to the **LAST MONTH** or so: | NOT AT ALL | LESS THAN 1 TIME IN 5 | LESS THAN 1/2 THE TIME | ABOUT 1/2 THE TIME | MORE THAN 1/2 THE TIME | ALMOST ALWAYS |
|---|---|---|---|---|---|---|
| **INCOMPLETE EMPTYING**: How often have you had a sensation of not emptying your bladder completely after you finished urinating? | **0** | **1** | **2** | **3** | **4** | **5** |
| **FREQUENCY**: How often have you had to urinate again less than two hours after you finished urinating? | **0** | **1** | **2** | **3** | **4** | **5** |
| **INTERMITTENCY:** How often have you stopped and started again several times when you urinated? | **0** | **1** | **2** | **3** | **4** | **5** |
| **URGENCY:** How often have you found it difficult to postpone urination? | **0** | **1** | **2** | **3** | **4** | **5** |
| **WEAK STREAM:** How often have you had a weak urinary stream? | **0** | **1** | **2** | **3** | **4** | **5** |
| **STRAINING:** How often have you had to push or strain to begin urination? | **0** | **1** | **2** | **3** | **4** | **5** |
| **NIGHTTIME:** How many times did you typically get up to urinate from the time you went to bed at night until the time you got up in the morning? | NONE<br>**0** | 1 TIME<br>**1** | 2 TIMES<br>**2** | 3 TIMES<br>**3** | 4 TIMES<br>**4** | 5 OR MORE<br>**5** |

| **QUALITY OF LIFE:** How would you feel if you had to live with your urinary condition the way it is now for the rest of your life? | DELIGHTED | PLEASED | MOSTLY SATISFIED | MIXED | MOSTLY DISSATISFIED | UNHAPPY | TERRIBLE |
|---|---|---|---|---|---|---|---|
| | **0** | **1** | **2** | **3** | **4** | **5** | **6** |

## SEXUAL HEALTH INVENTORY FOR MEN

| | | | | | | |
|---|---|---|---|---|---|---|
| How do you rate **your confidence** that you could get and keep an erection? | | VERY LOW<br>**1** | LOW<br>**2** | MODERATE<br>**3** | HIGH<br>**4** | VERY HIGH<br>**5** |
| When you had erections with sexual stimulation, **how often** were your erections hard enough for penetration (entering your partner)? | NO SEXUAL ACTIVITY<br>**0** | ALMOST NEVER OR NEVER<br>**1** | A FEW TIMES<br>**2** | ABOUT HALF THE TIME<br>**3** | MOST TIMES<br>**4** | ALMOST ALWAYS OR ALWAYS<br>**5** |
| During sexual intercourse, **how often** were you able to maintain your erection after you had entered your partner? | DID NOT ATTEMPT INTERCOURSE<br>**0** | ALMOST NEVER OR NEVER<br>**1** | A FEW TIMES<br>**2** | ABOUT HALF THE TIME<br>**3** | MOST TIMES<br>**4** | ALMOST ALWAYS OR ALWAYS<br>**5** |
| During sexual intercourse, **how difficult** was it to maintain your erection to completion of intercourse? | DID NOT ATTEMPT INTERCOURSE<br>**0** | EXTREMELY DIFFICULT<br>**1** | VERY DIFFICULT<br>**2** | DIFFICULT<br>**3** | SLIGHTLY DIFFICULT<br>**4** | NOT DIFFICULT<br>**5** |
| When you attempted sexual intercourse, **how often** was it satisfactory for you? | DID NOT ATTEMPT INTERCOURSE<br>**0** | ALMOST NEVER OR NEVER<br>**1** | A FEW TIMES<br>**2** | ABOUT HALF THE TIME<br>**3** | MOST TIMES<br>**4** | ALMOST ALWAYS OR ALWAYS<br>**5** |

**Urology**
1240 South Eliseo Drive, Suite 200, Greenbrae, CA 94904 | **O** 1-415-461-4000 | **F** 1-415-461-6907
3250 Beard Road, Napa, CA 94558 | **O** 1-415-461-4000 | **F** 1-415-461-6907
75 Rowland Way, Suite 200, Novato, CA 94945 | **O** 1-415-461-4000 | **F** 1-415-461-6907
1496 Professional Drive, Suite 603, Petaluma, CA 94954 | **O** 1-707-762-0059 | **F** 1-707-762-8011
651 1st Street West, Suite L, Sonoma, CA 95476 | **O** 1-415-461-4000 | **F** 1-415-461-6907
www.mymarinhealth.org/urologyclinic

Connect with us