SCOTT D. DUDAK, MD, FACS
Urology and Urologic Surgery

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PATIENT HISTORY FORM

Today's Date	Date of Birth	Age
Last Name	First Name, Middle Initial	☐ Male ☐ Female

History of Present Illness

Reason for this visit: ____

____

____

____

Duration of above complaint. Please indicate number: ____ week(s) ____ month(s) ____ year(s)

Have you been treated for this condition in the past? ☐ Yes ☐ No **If yes, please explain:**

____

Frequency of urination: Daytime: ____ Nighttime: ____ Strength of stream: ☐ Normal ☐ Decreased ☐ Poor

Are you currently experiencing any of the following symptoms? Please indicate yes or no for each.

		Comments			*Comments*
Blood in urine	☐ Yes ☐ No	________	Leakage of urine	☐ Yes ☐ No	________
Urinary infections	☐ Yes ☐ No	________	Interruption of urinary stream	☐ Yes ☐ No	________
Kidney or bladder stones	☐ Yes ☐ No	________	Split stream	☐ Yes ☐ No	________
Urgent urination	☐ Yes ☐ No	________	Burning or discomfort with urination	☐ Yes ☐ No	________
Dribbling after voiding	☐ Yes ☐ No	________	Hesitancy in initiating stream	☐ Yes ☐ No	________

Recent X-Rays ☐ Yes ☐ No ________ If yes, what type of X-rays were performed and where?

____

Physician Use Only:

____

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Past Medical and Social History

List any serious illnesses or surgeries you have had and when they occurred (in chronological order with approximate dates).

____

____

____

____

List all serious illnesses in your immediate family. (Example: diabetes, cancer, heart disease, elevated cholesterol, hypertension, etc.)

____

____

Are you currently taking any prescription or nonprescription medications? (Example: aspirin; ibuprofen; hormone replacements; dietary, herbal or vitamin supplements) ☐ Yes ☐ No **If yes, list all.**

____

____

____

____

Do you have any allergies to medications, latex, iodine contrast or adhesives? ☐ Yes ☐ No **If yes, list all.**

____

Have you ever had a blood transfusion? ☐ Yes ☐ No **If yes, when?**

____

Do you currently smoke? ☐ Yes ☐ No If yes, how many packs per day? _____ For how many years? ___

If you have a history of smoking, when did you stop? ___/___/___ Packs per day? ___ How many years? ___

Do you currently drink alcoholic beverages? ☐ Yes ☐ No

If yes, how much and how often? _________________________ For how many years? ___

If you have a prior history of drinking, when did you stop? ___/___/___

Physician Use Only:

____

____

____

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Review of Systems

Do you have, or have you had, problems related to the following? Please indicate yes or no for each.

General			**Integumentary**		
Fever	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Chills	☐ Yes	☐ No	Persistent Itch	☐ Yes	☐ No
Weight Loss	☐ Yes	☐ No			
Other:	☐ Yes	☐ No			
Eyes			**Musculoskeletal**		
Vision Problems	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Back Pain	☐ Yes	☐ No
Other:	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Allergic			**Ear/Nose/Throat**		
Penicillin	☐ Yes	☐ No	Dry Mouth	☐ Yes	☐ No
Sulfa	☐ Yes	☐ No	Sinus Problem	☐ Yes	☐ No
IV Contrast	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Other:	☐ Yes	☐ No			
Neurological			**Respiratory**		
Dizzy Spells	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No
Stroke (CVA)	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Tremors	☐ Yes	☐ No	Wheezing	☐ Yes	☐ No
Other:	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Endocrine			**Hematological/Lymphatic**		
Diabetes	☐ Yes	☐ No	Immune Disorder	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	Blood Clotting Disorder	☐ Yes	☐ No
Excess Thirst	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Heat/Cold Intolerance	☐ Yes	☐ No			
Other:	☐ Yes	☐ No			
Gastrointestinal			**Urological/Renal**		
Nausea/Vomiting	☐ Yes	☐ No	Urinary Infections	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	Kidney Disease/Failure	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Erectile Dysfunction (men)	☐ Yes	☐ No
Other:	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Cardiovascular			**Psychological**		
Chest Pain/Angina	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No			
Other:	☐ Yes	☐ No			