UROLOGY SPECIALISTS OF SANTA BARBARA

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PATIENT INFORMATION		
Name:	Date of birth:	Current Age:
Today's date:	Referring doctor:	Primary Care doctor:
What is the reason for your visit today:		

MEDICAL HISTORY - Please list significant illnesses such as high blood pressure, heart disease, cancer, diabetes, etc.	
1.	5.
2.	6.
3.	7.
4.	8.

OPERATIONS (SURGERY)	REASON	DATE
1.		
2.		
3.		
4.		
5.		

MEDICATIONS	DOSAGE	HOW OFTEN?		ALLERGIES (food or drug)
1.				1.
2.				2.
3.				3.
4.				4.
5.				5.
6.				6.

FAMILY HISTORY - Please indicate the health problems in your immediate family such as high blood pressure, heart disease, cancer (especially urologic cancer), diabetes, etc.

Relative	Health Problem (or cause of death)	Deceased? (Y / N)	Age (or age at death)

SOCIAL HISTORY/HABITS
Birthplace: Marital status (circle): Single Married Divorced Widowed Separated
With whom do you live? Number of children:
Occupation(s) - past and present:
Hobbies and interests:
Do you smoke? _____ If so, how many packs per day? _____ For how many years? _____ If you stopped, when did you quit? _____

See Reverse Side of Form

Do you drink alcohol? ____ If so, average number of drinks per day (including beer and wine):____
Caffeine: _____ cups/day (coffee, tea, sodas) Other fluids _____glasses per day
Do you, or have you ever, used other drugs? If so, what types and when?
Have you been or are you on a special diet?

UROLOGY HISTORY
How often do you urinate during the day? How many times at night?
Is your urinary stream?: ❑ Strong ❑ Medium ❑ Slightly Weak ❑ Very Weak
Do you have trouble starting the stream? ❑ Yes ❑ No ❑ Sometimes
Do you have trouble stopping the flow of urine? ❑ Yes ❑ No ❑ Sometimes
Is there pain or burning with urination? ❑ Yes ❑ No ❑ Sometimes
Do you have pain in your sides or lower abdomen? ❑ Yes ❑ No
Have you seen any blood in your urine? ❑ Yes ❑ No
Do you have a problem with urinary leakage? (describe)
Have you had any prior urinary tract infections or venereal diseases?
Have you had any prior urinary stones?
Did you have any childhood urinary problems?
Have you had any previous urology testing or treatment? (describe)
OPTIONAL INFORMATION
Women: # Pregnancies _____, # children _____ Have you have a hysterectomy? _____ Any dryness, pain with sex, loss of sex drive?
Men: Any problems with erections, sex drive?

REVIEW OF SYSTEMS (Circle if symptoms present**)**	
General: fever, chills, headache, weight loss, poor appetite	Respiratory: wheezing, frequent cough, shortness of breath
Eyes: blurred vision, double vision, loss of vision, pain	Muscle/joint: joint pain, bone pain, back pain,
Ears, etc: ear infections, sore throat, sinus problems	Skin: rashes, persistent itching, boils
Endocrine: excessive thirst, fatigue, too hot/cold, Diabetes, thyroid problems	Neurological: tremors, dizzy spells, numbness, Seizures
GI: abdominal pain, nausea, vomiting, indigestion, constipation, diarrhea	Blood/lymph: swollen glands, blood clotting problems, easy bruising
Cardiac: chest pains, irregular heart beat	Psychological: depression, sudden mood changes
Is there anything else we should know about you?	
Other Comments:	