McIver Urological Clinic – Male Information Sheet

Patient Name: _____ DOB: _____ Date: _____

Pharmacy name and phone number: _____

****

Reason for todays visit: _____

Allergies: _____

Family History of:

Prostate Cancer	Yes	No	_____
Bladder Cancer	Yes	No	_____
Other Urologic Cancers	Yes	No	_____

Other Family History:

_____

_____

_____

Medical History:

Diabetes:	Yes	No	
Hypertension:	Yes	No	
Heart Disease:	Yes	No	Explain: _____

Other medical history:

_____

_____

_____

Surgical History:

Heart stents:	Yes	No	Explain: _____
CABG/Bypass:	Yes	No	Explain: _____

Other surgical history:

_____

_____

_____

Married: Yes No **Occupation:** _____

Smoke: Yes _____ppd No Never **Alcohol Use:** Yes No Social

Current medications:

_____

_____

_____

Do you take antibiotics prior to any procedures? Yes No

Over

Review of Systems – Male

Please circle if you experience any of the following:

General:

Headache	Y	N
Fever	Y	N
Weight loss >10 lbs	Y	N
Chills	Y	N
Dietary Changes	Y	N

Skin:

Boils	Y	N
Rash	Y	N
Itching	Y	N

Head, Eyes, Ears, Nose, Throat:

Sinus problems	Y	N
Eye pain	Y	N
Ear infection	Y	N
Sore throat	Y	N
Blurred vision	Y	N
Double vision	Y	N

Neck:

Neck mass	Y	N

Respiratory:

Shortness of breath	Y	N
Wheezing	Y	N

Breast:

Breast swelling	Y	N

Cardiovascular:

Chest pain	Y	N
Hypertension	Y	N
Orthopnea	Y	N
Difficulty breathing on exertion	Y	N

Gastrointestinal:

Abdominal pain	Y	N
Change in bowels habits	Y	N
Heartburn	Y	N

Musculoskeletal:

Joint pain	Y	N
Back pain	Y	N

Neurological:

Numbness/Tingling	Y	N
Tremors	Y	N
Dizziness	Y	N

Psychiatric:

Severe depression	Y	N

Endocrine:

Tired/Sluggish	Y	N
Sexual Dysfunction	Y	N
Excessive thirst	Y	N

Hematology:

Blood clotting problems	Y	N
Swollen glands	Y	N

Genitourinary:

Painful urination	Y	N
Flank pain	Y	N
Frequency	Y	N
Blood in urine	Y	N
Hesitancy	Y	N
Impotence	Y	N
Incontinence	Y	N
Testicular mass	Y	N
Testicular pain	Y	N
Discharge	Y	N
Urgency	Y	N
Urine retention	Y	N

Nighttime urination Y N #_____