Dallas Center for Pelvic Medicine

Patient History Form

Patient Name_____ **Date**:_____

Reason for your visit today_____

Name of referring physician _____**Physician phone number**_____

Drug allergies:_____ **ALLERGY TO:** ___Latex? ___IV Contrast? ___Iodine?

RACE: White ___ Black ___ Asian ___ Hispanic ___ Other _____ **Occupation**_____

Do you take antibiotics before going to the dentist office? Y / N If so, for what condition? _____

If so, what do you usually take prior to dental procedures? _____ **Height** _____ **Weight** _____

Past Medical History:					
Cancer	Y / N	Hepatitis (Type: A / B / C)	Y / N	Thyroid disorder	Y / N
Diabetes	Y / N	Hypertension (high BP)	Y / N	Other:	
Fibromyalgia	Y / N	Irritable bowel syndrome	Y / N		
Heart disease	Y / N	Kidney stones	Y / N		

List all the surgeries you have had in the past

Surgery:	**Year**	**Surgery:**	**Year:**

Social History:		
Alcohol	Y / N	____ drinks per day / week / month
Street drugs/drug abuse	Y / N	Type of drugs:
Smoking/Tobacco	Y / N	____ packs per day; _____# years; cigars _____; pipe _____
Did you quit smoking?	Y / N	How long ago?
Regular exercise	Y / N	____ # minutes ; ____ # times per week
Caffeine use	Y / N	____ # servings per day
Marital status: (circle) single married widow/widower		
Female Only: Last menstrual period / /		Female Only: Birth control method
Female Only: Onset of menopause / /		Female Only: Hormone replacement use: Currently Previously Never
Female Only: # pregnancies _____ # births _____ # miscarriages _____ # abortions _____		

Family History:		**Family member affected**
Cancer: list type and location	Y / N	
Any family member on dialysis	Y / N	
Heart disease	Y / N	
Hypertension	Y / N	
Kidney stone disease	Y / N	
Renal cysts or tumors	Y / N	
Renal failure	Y / N	
Sickle cell disease or trait	Y / N	

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Review of Systems

Patient Name:_____ Date:_____

Check any problems you are having?

Abdominal pain		Indigestion / heartburn	
Back pain		Joint pain	
Blood clotting problems		Joint swelling	
Blood in urine		Leakage of urine	
Blurred vision		Nausea / vomiting	
Burning with urination		Neck pain	
Chest pain		Numbness / tingling	
Chills		Painful urination	
Cold intolerance		Palpitations	
Constipation		Persistent itch	
Cough		Rash	
Depression		Shortness of breath	
Diarrhea		Sinus problems	
Difficulty emptying bladder		Slow urine stream	
Dizziness		Sore throat	
Double vision		Swollen lymph nodes	
Elevated BP		Tired / sluggish	
Extreme thirst		Tremors	
Fecal incontinence		Urinary frequency	
Fecal urgency		Urinary hesitancy	
Fever		Urinary urgency	
Hay fever symptoms		Urinating frequently at night	
Headache		Varicosities (varicose veins)	
Heat intolerance		Weakness	
Inability to empty bladder		Wheezing	

MEDICATION (including non-prescription)	DOSE	TIMES PER DAY

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Urology Specific Review

Patient Name:_____ Date:_____

Do you have any problems urinating? ☐ YES ☐ NO

Obstructive Symptoms

Is your stream normal?	YES	NO
Is your stream slow?	YES	NO
Is your stream a dribble of urine?	YES	NO
Do you spray when you urinate?	YES	NO
Is your stream split?	YES	NO
Does it take time to start your flow?	YES	NO
Do you have intermittent flow?	YES	NO
Do you void again within 1-hour of the first?	YES	NO
Do you strain to void?	YES	NO
Do you feel incompletely emptied after voiding?	YES	NO
Do you have dribbling after you are done?	YES	NO
Does your stream just abruptly stop in the middle?	YES	NO
Have you ever not been able to urinate, where a catheter had to be placed?	YES	NO

Irrative symptoms

Do you have frequent urination? If yes, how often? _____ hours	YES	NO
Do you get up at night to urinate?	YES	NO
Do you have urgent urination?	YES	NO
Does it burn when you urinate?	YES	NO
Do you leak urine?	YES	NO
Does it happen when you cough or strain?	YES	NO
Does it happen with exercise?	YES	NO
Does it happen with running water?	YES	NO
Does it happen at your front door?	YES	NO
Do you have a pain in your lower abdomen at the time?	YES	NO
Do you just not make it to the bathroom fast enough?	YES	NO
Have you seen blood (red or tea colored) in your urine?	YES	NO
If yes, is it?		
Painless?	YES	NO
At the beginning of urination?	YES	NO
In the middle of urination?	YES	NO
At the end of urination?	YES	NO
Is it throughout the stream?	YES	NO
Have you ever had problems with urinary tract infection?	YES	NO
Have you ever had kidney stones?	YES	NO
If yes,		
How many times?		
What type of treatment?		

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Urology Specific Review: Men Only

Patient Name:_____ Date:_____

Value of last PSA: Date:		
Date of last prostate exam:		
History of prostate infections (prostatitis)?	YES	NO
Do you have a penile discharge?	YES	NO
If yes,		
When did it start?		
What color is it?		
What is the consistency?		
Are you having problems with getting your partner pregnant?	YES	NO
If so,		
How long have you been trying? years		
Do you have any problems with ejaculation?	YES	NO
If yes,		
Have you ever had blood (red or tea colored) in your semen?	YES	NO
Do you have problems with premature ejaculation?	YES	NO
Do you have problems with getting orgasms?	YES	NO
Does your volume of semen seem less than usual?	YES	NO
Do have any problems getting an erection?	YES	NO
If yes, when did it start? Months Years		
Sudden onset?	YES	NO
Gradual onset?	YES	NO
Are you still interested in sex?	YES	NO
Are you and your partner satisfied after?	YES	NO
Do you get adequate erections when you wake up?	YES	NO
Do you ever wake up at night with an adequate erection for intercourse?	YES	NO
When was your last successful encounter?		
Do you have any curvatures of the penis?	YES	NO
Are there any hard areas on the penis?	YES	NO
Do you have pain with intercourse?	YES	NO
Do you have a stressful job?	YES	NO
Has there been a recent stressful family situation?	YES	NO
Do you suffer from depression?	YES	NO