St. Elizabeth's Medical Center
A STEWARD FAMILY HOSPITAL
Steward

Problem List & Patient History Form

Reason for Visit

General

□ Frequency □ Painful Urination □ Nocturia □ Urinary Tract Infections
□ Retention □ Hesitancy □ Blood in Urine □ Erectile Dysfunction

Incontinence (Urinary Leakage)

□ Urgency □ Stress □ Bed Wetting

Pain

□ Flank □ Back □ Testicular □ Abdominal

Cancer

□ Prostate Cancer □ Bladder Cancer □ Kidney Cancer □ Testicular Cancer

Other Reason _____

Past Medical History

□ Frequency □ Urgency □ Nocturia □ Blood in Urine
□ High Cholesterol □ Diabetes □ Heart Disease □ High Blood Pressure
□ Asthma □ Kidney Stones □ Epilepsy □ Urinary Tract Infections
□ Migraines □ Thyroid Problems □ Stroke □ Erectile Dysfunction
□ Prostate Cancer □ Bladder Cancer □ Kidney Cancer □ Testicular Cancer
□ Prostatitis □ Urethral Cancer □ Colon Cancer □ Enlarged Prostate
□ Other _____

Past Surgical History

□ Appendectomy □ Tonsillectomy □ Heart Bypass □ Hysterectomy
□ Vasectomy □ Prostate □ TURP □ ESWL
□ Stone Removal □ Hernia Repair □ Cataracts □ Gallbladder
□ Cystectomy □ Colon Surgery □ Bladder Sling □ Cystocele
□ Knee Replacement □ Hip Replacement □ Gastric Bypass □ Back Surgery
□ Other _____

Family History

****If you answer Yes to any of the following questions please list how the person/people are related to you.**

			Relationship
Similar condition?	Yes ____	No ____	_____
Heart disease?	Yes ____	No ____	_____
Bladder Cancer?	Yes ____	No ____	_____
High blood pressure?	Yes ____	No ____	_____
Diabetes?	Yes ____	No ____	_____
Kidney Stones?	Yes ____	No ____	_____
Prostate Cancer?	Yes ____	No ____	_____
Urinary Tract Infections?	Yes ____	No ____	_____
Liver disease?	Yes ____	No ____	_____
Other _____			_____
Other _____			_____

□Married □Single □Widowed □Divorced

How many children do you have? _____ How many deliveries? _____
Vaginal _____ C-Section _____

Do you currently smoke? □ Y □ N Are you a former smoker? □ Y □ N When did you quit? _____

If yes, how many packs per day? _____ For how many years? _____
Occupation _____

Please fill out the condition that pertains to you.

Kidney Stones

How long have you had the stone? _____

Have you ever had kidney stones before? _____ Yes _____ When _____ No

If yes, how was the stone treated? _____ Passed _____ Surgery

How bad is the pain? _____ Mild _____ Moderate _____ Severe

Have you had x-rays taken? If yes, please specify when and where.

_____ No _____ Yes_____

Blood in Urine

How long has this problem been going on? _____

Can you see the blood in your urine? _____ Yes _____ No

How often does this problem happen? _____

Have you had x-rays taken? If yes, please specify when and where.

_____ No _____ Yes_____

Infection

How long has this problem been going on? _____

Have you ever taken medication to fix the problem? If yes, please list all meds taken.

_____ No _____ Yes_____

How often does this problem happen? _____

How bad is the problem? _____ Mild _____ Moderate _____ Severe

Sexual Problem

Please describe your problem. _____

_____

How long has this problem been going on? _____

Have you ever taken medication to fix the problem? If yes, please list all meds taken. _____ No

_____ Yes _____

How often does this problem happen? _____

How bad is the problem? _____ Mild _____ Moderate _____ Severe

Have you ever had surgery to fix the problem? If yes, please list surgeries and when you had them done.

_____ No _____ Yes_____

Prostate Problem

Please describe your problem. _____

How long has this problem been going on? _____

How bad is it? _____ Mild _____ Moderate _____ Severe

Have you ever taken medication to fix the problem? If yes, please list all meds taken.

_____ No _____ Yes_____

How often does this problem happen? _____

What was your last PSA? _____ When? _____