McKay Urology – Patient History

Patient Name: ____

Date of Birth: ____

Date of Visit: ____

Pharmacy: ____

Previous Urologist: ____________________________________

Primary Care Physician: _________________________________

Group/Practice/Location:_________________________________

Referring Provider: ____________________________________

Male Patients

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Patient Name: ____ **Chart #:** ____________________

Review of Systems

- **Please mark ☒ any condition which applies to you.**

General
- ☐ fever
- ☐ chills
- ☐ weakness
- ☐ fatigue

Head and Neck
- ☐ visual disturbances
- ☐ decreased hearing
- ☐ nasal congestion
- ☐ sore throat

Pulmonary
- ☐ shortness of breath
- ☐ cough
- ☐ sputum production
- ☐ wheezing

Cardiovascular
- ☐ chest pain
- ☐ palpitations (irregular heart beat)
- ☐ edema (leg swelling)
- ☐ fainting

Gastrointestinal
- ☐ nausea
- ☐ vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ heartburn
- ☐ abdominal pain

Genitourinary
- ☐ burning on urination
- ☐ bloody urine
- ☐ change in urine stream

Hematopoietic/Lymphatic
- ☐ bruising tendency
- ☐ bleeding tendency
- ☐ swollen lymph glands

Musculoskeletal
- ☐ back pain
- ☐ neck pain
- ☐ joint pain
- ☐ muscle pain

Immunologic
- ☐ immunocompromised
- ☐ recurrent fever
- ☐ recurrent infections

Neurologic
- ☐ abnormal balance
- ☐ confusion
- ☐ numbness
- ☐ tingling
- ☐ headaches

Psychiatric
- ☐ anxiety
- ☐ depression

_________________________ _________________________
(Patient initials) (Date)

Medical Condition History
- Please check any of the following conditions you have or have had in the past.

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- If none of these conditions apply to you, please proceed to the next page.
- If you are unsure, please ask a staff member to assist you in filling out this form.
- You may have more than one condition.

If you have no medical problems, please check this box: ☐ No medical problems.

☐ Alzheimer's/Dementia
☐ Anemia
☐ Asthma
☐ Arthritis
☐ Blood clot (DVT)
☐ Cancer/Type: ___________________________
Cancer treatment:
☐ radiation ☐ chemotherapy ☐ surgery
☐ Cardiac arrhythmia (abnormal heart rate)
☐ Congestive heart failure
☐ Coronary artery disease
☐ Other heart disease
☐ Cerebrovascular disease (stroke)
☐ Depression
☐ Diabetes
☐ Other endocrine disorder (gland problem, ex: Thyroid)
☐ Emphysema (COPD)
☐ Glaucoma
☐ Heart murmur
☐ Other lung disease
☐ Hypertension (high blood pressure)
☐ Hypercholesterolemia (elevated cholesterol)
☐ Kidney stones
☐ Kidney Failure
☐ Liver disorder (Cirrhosis, Hepatitis)
☐ Mitral valve prolapse
☐ Multiple sclerosis
☐ Parkinson's disease
☐ Sleep apnea
☐ Other medical problem (specify):

____

Surgery/Procedures: Have you had surgery? ☐ Yes ☐ No
Please check any surgeries/procedures you have had and give the year the procedure was performed.

Surgery:	**Year**
☐ Appendectomy	_________________
☐ Bladder suspension	_________________
☐ CABG (Coronary artery bypass grafting)	_________________
☐ Cardiac stents	_________________
☐ Cholecystectomy (removal of Gallbladder)	_________________
☐ Hernia repair – Type: _________________________	_________________
☐ Lithotripsy – ESWL (stone machine)	_________________
☐ Mastectomy - ☐ Right ☐ Left	_________________
☐ Prostatectomy (removal of prostate)	_________________
☐ Splenectomy (removal of spleen)	_________________
☐ Tonsillectomy	_________________
☐ Vasectomy	_________________
☐ Other surgery (1) _________________________	_________________
☐ Other surgery (2) _________________________	_________________
☐ Other surgery (3) _________________________	_________________

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Allergies: Are you allergic to any **medications**? ☐ Yes ☐ No

Specify allergic medications:	**Describe reaction**
1. ______________________	☐ anaphylactic shock, ☐ bronchospasm, ☐ rash, ☐ nausea, ☐ other ______________
2. ______________________	☐ anaphylactic shock, ☐ bronchospasm, ☐ rash, ☐ nausea, ☐ other ______________
3. ______________________	☐ anaphylactic shock, ☐ bronchospasm, ☐ rash, ☐ nausea, ☐ other ______________
4. ______________________	☐ anaphylactic shock, ☐ bronchospasm, ☐ rash, ☐ nausea, ☐ other ______________

Are you allergic to Latex? ☐ **Yes** ☐ **No**

Are you allergic to Betadine ☐ **Yes** ☐ **No**

Are you allergic to IV contrast/Iodine ☐ **Yes** ☐ **No**

Current Medications – Prescription and over the counter medications
(including vitamins, herbs, aspirin, antacids, injectables, hormones and birth control medication.

Medication:	**Dosage**	**How often do you take this?**
1. ______________	__________	______________
2. ______________	__________	______________
3. ______________	__________	______________
4. ______________	__________	______________
5. ______________	__________	______________
6. ______________	__________	______________
7. ______________	__________	______________
8. ______________	__________	______________
9. ______________	__________	______________
10. ______________	__________	______________
11. ______________	__________	______________
12. ______________	__________	______________
13. ______________	__________	______________
14. ______________	__________	______________
15. ______________	__________	______________
16. ______________	__________	______________
17. ______________	__________	______________

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Cancer History: **Please check cancers you have had in the past and past treatments.**

Have you ever been diagnosed with cancer? ☐ Yes ☐ No.

If yes, please fill in the table using the list below. If no, you may skip the remainder of this section.

- Types of Primary Cancer:

☐ Bladder
☐ Bone
☐ Brain/central nervous system
☐ Breast
☐ Cervix
☐ Colon/rectum
☐ Connective tissue/muscles
☐ Esophageal
☐ Female reproductive: site unknown
☐ Head/neck
☐ Leukemia
☐ Liver
☐ Lung
☐ Lymphatic
☐ Melanoma
☐ Ovary
☐ Pancreas
☐ Prostate
☐ Renal (kidney
☐ Sarcomas
☐ Skin (other than melanoma)
☐ Stomach
☐ Testis
☐ Uterus
☐ Unknown
☐ Other (not listed here)

- Types of Treatment

☐ Chemotherapy
☐ Gene therapy
☐ Hormone therapy
☐ Immunotherapy
☐ Radiotherapy
☐ Surgery
☐ Other (not listed here)

Family Medical History: **Please check all diseases for which you have a family history:**

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Other: ________________________

If cancer, type: ____

Father: ☐ Alive ☐ Deceased Age ________ (Age deceased or current age if still alive)

Cause of death or current conditions:

____

Mother: ☐ Alive ☐ Deceased Age ________ (Age deceased or current age if still alive)
Cause of death or current conditions:

____

Level of Education:

☐ grade school ☐ high school/equivalent ☐ some college ☐ college degree ☐ graduate degree

Habits:

Alcohol: ☐ I drink alcohol
☐ I do not drink alcohol, but I used to drink alcohol
☐ I never drink alcohol

If you do drink alcohol, how many drinks do you average per week? ______ per week

Number of years of this pattern? _________ years.

Previous maximum alcohol use: ☐ none ☐ same as above ☐ different from above

If different, # of drinks per week? ___________ Years of use at this pattern? ________ years

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Tobacco: ☐ I use tobacco
☐ I do not use tobacco, but I used to use tobacco
☐ I have never used tobacco

If you use tobacco, how much?

# of cigarette packs per day:? ___________ # of Cigars per week? _________________

# of pipe bowls per day? ____________ # of snuff, dip, or chew packages per week? ___________

Previous maximum tobacco use: ☐ none ☐ same as above ☐ different from above

If different, how much?

# of cigarette packs per day:? ___________ # of Cigars per week? _________________

# of pipe bowls per day? ____________ # of snuff, dip, or chew packages per week? ___________

# of years of use at this pattern? __________ years.

Date of last tobacco use: ______________________

Current daily caffeine use:

Cups of coffee per day: __________ 1 cup = 8 oz.

Glasses of tea per day: ___________ 1 glass = 12 oz.

Glasses of soda per day: __________ 1 glass = 12 oz.

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AUA Symptom Index

Check ONLY ONE answer for each question

1. Over the past month, how often have you had the sensation of not emptying your bladder completely after you finished urinating?

☐ 0 Not at all
☐ 1 Less than one time in five
☐ 2 Less than half the time
☐ 3 About half the time
☐ 4 More than half the time
☐ 5 Almost always

2. Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?

☐ 0 Not at all
☐ 1 Less than one time in five
☐ 2 Less than half the time
☐ 3 About half the time
☐ 4 More than half the time
☐ 5 Almost always

3. Over the past month, how often have you found you stopped and started again several times when you urinated?

☐ 0 Not at all
☐ 1 Less than one time in five
☐ 2 Less than half the time
☐ 3 About half the time
☐ 4 More than half the time
☐ 5 Almost always

4. Over the past month, how often have you found it difficult to postpone urination?

☐ 0 Not at all
☐ 1 Less than one time in five
☐ 2 Less than half the time
☐ 3 About half the time
☐ 4 More than half the time
☐ 5 Almost always

5. Over the past month, how often have you had a weak urinary stream?

☐ 0 Not at all
☐ 1 Less than one time in five
☐ 2 Less than half the time
☐ 3 About half the time
☐ 4 More than half the time
☐ 5 Almost always

6. Over the past month, how often have you had to push or strain to begin urination?

☐ 0 Not at all
☐ 1 Less than one time in five
☐ 2 Less than half the time
☐ 3 About half the time
☐ 4 More than half the time
☐ 5 Almost always

7. Over the past month, how many times did you most typically urinate from the time you went to bed at night to the time you got up in the morning?

☐ 0 None
☐ 1 One time
☐ 2 Two times
☐ 3 Three times
☐ 4 Four times
☐ 5 Five times or more

If you were to spend the rest of your life with your voiding symptoms just as they are now, how would you feel about that?

☐ Delighted ☐ Pleased ☐ Mostly satisfied ☐ Mixed ☐ mostly dissatisfied ☐ Unhappy ☐ Terrible

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FOR MALES ONLY

Have you ever been diagnosed with prostate cancer? ☐ Yes ☐ No

Date of diagnosis or positive biopsy: ☐ ☐ / ☐ ☐ ☐ ☐ (month/4 digit year)

Stage of Previous PCa: ☐ ☐ ☐ Grade of Previous PCa ☐ ☐

Please check any previous prostate related procedures/treatments/surgeries you have received. Year(s)

Procedure	Year(s)
☐ Prostate biopsy	☐ ☐ ☐ ☐
☐ Open simple prostatectomy (for BPH – enlarged prostate)	☐ ☐ ☐ ☐
☐ Transurethral resection of prostate (TURP – “roto-rooter”)	☐ ☐ ☐ ☐
☐ Vaporization of prostate to improve voiding (“roto-rooter”)	☐ ☐ ☐ ☐
☐ Laser ablation of prostate to improve voiding (“roto-rooter”)	☐ ☐ ☐ ☐
☐ Microwave hyperthermia or prostate to improve voiding	☐ ☐ ☐ ☐
☐ Transurethral needle ablation of prostate (TUNA)	☐ ☐ ☐ ☐
☐ Prostatectomy, radical (for cancer)	☐ ☐ ☐ ☐
☐ Radiation – prostate	☐ ☐ ☐ ☐
☐ Cryosurgery – prostate	☐ ☐ ☐ ☐
☐ Bilateral orchiectomy (removal of both testicles)	☐ ☐ ☐ ☐

Prostate Cancer Family History

Is there a history of prostate cancer in your family? ☐ Yes ☐ No

If yes, please check all affected individuals below. **If no**, please proceed to the next page.

Types of Treatment:

A. Prostate surgery – radical prostatectomy
B. Prostate surgery – TURP (“roto rooter”)
C. Removal of testes
D. Other hormonal therapy
E. Radiation
F. Expectant management (observation, no treatment)
G. Unknown

Relatives w/Prostate Cancer	Age diagnosis	Types of treatment (check all that apply)	Status
☐ Father	☐ ☐	☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G	☐ Alive ☐ Died of prostate cancer ☐ Died of other causes
☐ Brother	☐ ☐	☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G	☐ Alive ☐ Died of prostate cancer ☐ Died of other causes
☐ Brother (2)	☐ ☐	☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G	☐ Alive ☐ Died of prostate cancer ☐ Died of other causes
☐ Son	☐ ☐	☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G	☐ Alive ☐ Died of prostate cancer ☐ Died of other causes
☐ Uncle	☐ ☐	☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G	☐ Alive ☐ Died of prostate cancer ☐ Died of other causes
☐ Maternal Grandfather	☐ ☐	☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G	☐ Alive ☐ Died of prostate cancer ☐ Died of other causes
☐ Paternal Grandfather	☐ ☐	☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G	☐ Alive ☐ Died of prostate cancer ☐ Died of other causes

McKay Urology – Patient History

For males only

Sexual function survey (Brief IIEF)

Check ONLY ONE answer for each question

1. How do you rate your confidence that you could get and keep an erection?

☐ 1 very low ☐ 2 low ☐ 3 moderate ☐ 4 high ☐ 5 very high

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

☐ 0 no sexual activity
☐ 1 almost never or never
☐ 2 a few times (much less than half the time)
☐ 3 sometimes (about half the time)
☐ 4 most times (much more than half the time
☐ 5 almost always or always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetration (entered) your partner?

☐ 0 did not attempt intercourse
☐ 1 almost never or never
☐ 2 a few times (much less than half the time)
☐ 3 sometimes (about half the time)
☐ 4 most times (much more than half the time
☐ 5 almost always or always

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

☐ 0 did not attempt intercourse
☐ 1 extremely difficult
☐ 2 very difficult
☐ 3 difficult
☐ 4 slightly difficult
☐ 5 not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you?

☐ 0 did not attempt intercourse
☐ 1 almost never or never
☐ 2 a few times (much less than half the time)
☐ 3 sometimes (about half the time)
☐ 4 most times (much more than half the time
☐ 5 almost always or always