Maui Medical Group, Inc.
Health Care Excellence For Maui Since 1961

*Soren Carlsen, MD - Urologist*

# MEDICAL HISTORY

Patient Name_____ Age_____ Today's Date_____
Marital Status_____ How did you hear about us (physician, friend, ad)?_____
CURRENT OCCUPATION (please also state if retired)_____
Referring Physician_____ Primary Care Doctor _____

## HISTORY OF PRESENT ILLNESS

REASON for today's visit _____
LOCATION of the problem _____

**On a scale of 1-10 (10 being the most severe) circle the number that best describes the problem.**
1 2 3 4 5 6 7 8 9 10

**When did you first notice the problem?**
2 days ago 2 weeks ago 1 month ago
Other: _____

**Does anything make the problem better or worse?**
Moving around Standing up Lying on my side
Other: _____

**How long does the problem last?**
___Seconds ___Minutes ___Hours ___Always there

**Describe the problem Constant or Variable?**
Dull, Sharp or both, Very sharp then leaves
Other: _____

**Is anything else occurring at the same time?**
YES NO If yes, please explain_____

**Does the problem interfere with your normal functions?**
YES NO If yes, please explain_____

**Would you like to discuss erectile function?**
YES NO

**Would you like to discuss urine incontinence?**
YES NO

## PAST MEDICAL & SOCIAL HISTORY

**CHECK ALL OF THE FOLLOWING THAT APPLY**

**PERSONAL HISTORY OF:**

| | | | |
|---|---|---|---|
| __ALCOHOLISM | __DIABETES | __HEPATITIS | __KIDNEY STONES |
| __ARTHRITIS | __GOUT | __HERNIA : type_____ | __MULTIPLE SCLEROSIS |
| __ASTHMA | __HEART ATTACK | __HIGH BLOOD PRESSURE | __PARKINSON'S DISEASE |
| __CANCER(ANY)_____ | __HEART MURMUR | __HIGH CHOLESTEROL | __PROSTATE CANCER |
| __RECURRENT BLADDER/KIDNEY INFECTIONS | | OTHER:_____ | |

**PAST SURGICAL HISTORY OF: (*please specify if any are positive)***

| | | | |
|---|---|---|---|
| __PROSTATE_____ | __HYSTERECTOMY_____ | __BLADDER_____ | __URETHRA _____ |
| __CIRCUMCISION_____ | __VASECTOMY_____ | __GALL BLADDER | __HEART _____ |
| __HERNIA_____ | __INTESTINES_____ | __BACK/NECK_____ | __KIDNEY _____ |
| __KIDNEY STONE_____ | | __HIP/KNEE REPLACEMENT _____ | |

__CANCER(specify) _____
OTHER: _____

**FAMILY HISTORY OF:**

__PROSTATE CANCER __KIDNEY STONES OTHER: _____

**SOCIAL HISTORY OF:**

Do you now or did you ever smoke? Y N
How many packs/day____ Years smoked _____
When quit? _____
Do you drink alcoholic beverages? Y N
Type_____ Amount_____

Have you ever had a blood transfusion? Y N
Do you take Aspirin or blood thinner? Y N
Are you on a special diet? Y N
Are you sexually active? Y N

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Do you have allergies to any medications? Y N

Please list: _____

**Are you taking any prescription or non-prescription medications**? Y N

**Please list medications and dosages:**

| Medication Name | Dose |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## REVIEW OF SYSTEMS

Do you now or have you had any recent problems related to the following systems? Circle **Yes** or **No**.

**Please explain any Yes answers in space provided.**

**Constitutional Symptoms**
Fever Y N
Other/Comments _____

**Eyes**
Recent Vision Changes Y N
Other/Comments _____

**Cardiovascular**
Chest Pain Y N
Other/Comments _____

**Respiratory**
Cough Y N
Shortness of breath Y N
Other/Comments _____

**Gastrointestinal**
Abdominal pain Y N
Nausea/vomiting Y N
Other/Comments _____

**Genitourinary**
Urine retention (can't void) Y N
Urine incontinence (leakage) Y N
Urinary frequency Y N
Painful urination Y N
Erection difficulties Y N
Other/Comments _____

**Musculoskeletal**
Back Pain Y N
Other/Comments _____

**Integumentary**
Skin rash/lesions Y N
Other/Comments _____

**Neurological**
Headaches Y N
Lightheadedness Y N
Other/Comments _____

**Psychiatric**
Anxiety Y N
Other/Comments _____

**Hematologic/Lymphatic**
History of Blood Clots
(DVT or PE) Y N
Other/Comments _____

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# FEMALE UROLOGY QUESTIONNAIRE

Patient Name: _____ Date: _____

Do you now or have you had any **recent problems** related to the following systems?

**Urinary Incontinence (leakage)**

**How often do you experience urinary leakage (please circle one)**

| Never I do not leak | Less than once a month | A few times a month | A few times a week | and/or night |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

**How much urine do you lose each time (please circle one)**

| Never I do not leak | Drops | Small splashes | More |
|---|---|---|---|
| 0 | 1 | 2 | 3 |

***For office use only:***

ISI Score = _____ (*Multiply Q1 x Q2)*

None/Slight = 1 – 2
Moderate = 3 – 6
Severe = 8 – 9
Very Severe = 10 – 12

Do you wear pads due to leaking **Yes** **No**

How many in 24 hours _____

What kind/type/brand _____

Leaking with cough, laugh, movement? **Yes** **No**

Leaking with urgency (can't get to toilet in time) **Yes** **No**

**Overactive Bladder Symptoms**

Excessive urge to urinate **Yes** **No**

Excessive frequency of urination **Yes** **No**

How many urinations in 24 hrs _____

When you have the urge to urinate, how long can you delay? __seconds __minutes __hours __not at all

Average fluid intake per day (1 glass is 8oz/1cup) _____ glasses/day

How many cups of caffeinated beverages per day _____ glasses/day

**Circle any foods/drinks you commonly enjoy:**

Coffee Tea Cola Alcohol Citrus Fruits/Juices (orange, lemon, & etc.)
Tomato Spicy Foods Chocolate Pickled Foods Artificial Sweeteners

**Pain** Describe the pain _____

With urination **Yes** **No**

Relieved by urination **Yes** **No**

**Pelvic Organ Prolapse Symptoms**

Pressure in lower abdomen **Yes** **No**

Heaviness/dullness in the pelvis **Yes** **No**

Sensation on incomplete emptying **Yes** **No**

Have to push no vaginal bulge to start or complete urination **Yes** **No**

Bulge or something you see or feel falling out of the vaginal area **Yes** **No**

Have to push on the vagina or around the rectum to have or complete bowel movement **Yes** **No**