Urological History

Date of last prostate exam? _____ Physician who performed? _____

Physician's Phone Number _____

Date of last mammogram? _____ Facility where performed: _____

Facility Phone Number: _____

	YES	NO
Have you ever had an abnormal Prostate Exam? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had elevated PSA? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had a prostrate biopsy?		

Do you have a history of any of the following cancers:

- ☐ Lung
- ☐ Breast
- ☐ Colon
- ☐ Prostate
- ☐ Skin
- ☐ Lymphoma
- ☐ Leukemia
- ☐ Other: _____

_____

Hormone Therapy History

Have you been treated with any hormone replacement therapy? If yes, please give approximate Periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

Androgen Deficiency

Check which of these symptoms are troublesome and have persisted over time

- ☐ Low Libido
- ☐ Lack of Energy
- ☐ Decreased Strength/Energy
- ☐ Lost Height
- ☐ Decreased Enjoyment of Life
- ☐ Sad or Grumpy
- ☐ Problem with Memory/Concentration
- ☐ Decreased Erections
- ☐ Decreased Ability to Play Sports
- ☐ Fall Asleep After Dinner
- ☐ Sleep Disturbances
- ☐ Recent Deterioration of Work Performance
- ☐ Decreased Muscle Mass
- ☐ Hair Loss

Adrenals

Check which of these symptoms are troublesome and have persisted over time

Cortisol Excess		Cortisol Deficiency
☐ Sleep Disturbances	☐ Heart Palpitations	☐ Fatigue
☐ Bone Loss	☐ Headaches	☐ Sugar Craving
☐ Fatigue	☐ Stress	☐ Allergies
☐ Weight Gain – Waist	☐ Cold Body Temperature	☐ Chemical Sensitivity
☐ Loss of Muscle Mass	☐ Sugar Cravings	☐ Stress
☐ Thinning Skin	☐ Low Libido	☐ Cold Body Temperature
☐ Elevated Triglycerides	☐ Hair Loss	☐ Irritable
☐ Breast Cancer	☐ Increased Facial Hair	☐ Arthritis
☐ Irritable	☐ Increased Body Hair	☐ Heart Palpitations
☐ Anxious	☐ Acne	☐ Aches/Pains
☐ Memory Lapses	☐ Nervous	

Thyroid

Check which of these symptoms are troublesome and have persisted over time

Thyroid Excess	Thyroid Deficiency
☐ Heat Intolerance	☐ Cold Intolerance
☐ Voice has become hoarse	☐ Constipation
☐ Heart Palpitations	☐ Fatigued/Weakness
☐ Weight Loss	☐ Unexplained Weight Gain
☐ Tremors/Shakiness	☐ Inability to Lose Weight
☐ Diarrhea	☐ Stress
☐ Nervousness/Anxious/Panic Attacks	☐ Cold Body Temperature
☐ Muscle Weakness	☐ Irritable
☐ Difficulty Conceiving/Infertility	☐ Lack of Motivation
☐ Coarse Dry Skin	☐ Muscle Cramps
☐ Insomnia	☐ Aches/Pains

System Review – Check the appropriate box for each question.

Constitutional / ID / Oncology	Yes	No	Not Sure
Have you had unexplained weight loss?			
Do you have fever and chills?			
Do you have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive for HIV?			
Have you ever had a sexually transmitted disease?			
Respiratory			
Do you have a persistent cough?			
Do you frequently sneeze?			
Do you have excessive daytime sleepiness?			
Do you snore?			
Have you ever been diagnosed with asthma or emphysema or sleep apnea?			

System Review – Check the appropriate box for each question.			
Cardiovascular	**Yes**	**No**	**Not Sure**
Do you have chest pain?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Have you been diagnosed with any heart condition? Have you ever been diagnosed with a blood clot?			
Gastrointestinal			
Do you have problems swallowing food?			
Do you have nausea or vomiting?			
Do you have diarrhea?			
Do you have blood in your stool?			
Do you have abdominal pain or swelling?			
Have you ever been diagnosed with hepatitis or liver disease?			
Endocrine			
Do you urinate frequently or in larger amounts than usual?			
Do you have greater than normal urge to eat?			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem?			
Neurological			
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experienced double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
Urologic / Renal			
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing?			
Have you ever had any kidney problems?			

Physician Notes: