MCKAY UROLOGY – LINCOLNTON OFFICE
PATIENT HISTORY FORM

Patient name: _____

MRN #: _____

Current Medications (prescription and over the counter medications including vitamins, herbs, aspirin, antacids, injectables, hormones and birth control medication)

<u>If you brought a medication list or medication bottles with you, omit this section.</u>

Medication:	Dosage	How often do you take this?

Do you have any allergies to any medications? ☐ No ☐ Yes (please list below)

_____

_____

_____

Are you allergic to latex? ☐ Yes ☐ No

<u>Surgery/Procedures</u>: 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	_____
☐ Cardiac stents	_____
☐ Cataracts	_____
☐ CABG (Coronary artery bypass grafting)	_____
☐ Cholecystectomy (removal of Gallbladder)	_____
☐ C-Section	_____
☐ Cystocele repair	_____
☐ Hysterectomy ☐ abdominal ☐ vaginal	_____
☐ Mastectomy ☐ right ☐ left	_____

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☐ Tonsillectomy _____
☐ Vasectomy _____
☐ Other surgery _____ _____

Medical Condition History

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

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

☐ Blood clot (DVT)
☐ Cancer/Type:
_____
Cancer treatment:
- ☐ radiation
- ☐ chemotherapy
- ☐ surgery

☐ Diabetes
☐ Heart disease:
- ☐ Arrhythmia (abnormal heart rate)
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Heart murmur
- ☐ Other heart disease
- ☐ Cerebrovascular disease (stroke)

☐ High blood pressure
☐ Lung disease
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia

☐ Thyroid problems
☐ Glaucoma
☐ Liver disorder (cirrhosis, hepatitis)
☐ Sleep apnea
☐ Other medical problem (specify):
_____
_____

Family medical history: Please check all diseases for which you have a family history:

Mother	☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Other: _____
Father	☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Other: _____

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Maternal Grandmother	☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Other: _____
Paternal Grandmother	☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Other: _____
Maternal Grandfather	☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Other: _____
Paternal Grandfather	☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Other: _____
Siblings	☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Other: _____

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Patient name:

_____

Please check yes or no to any condition which you have experienced in the last 30 days.

Constitutional

Fever	☐ Yes	☐ No
Sweats	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No

Eye

Visual Problems	☐Yes	☐ No
Blurring	☐Yes	☐ No
Double Vision	☐Yes	☐ No

Ears, Nose, Mouth & Throat

Decreased Hearing	☐Yes	☐ No
Nasal Congestion	☐Yes	☐ No
Sore Throat	☐Yes	☐ No

Respiratory

Shortness of Breath	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Sputum Production	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

Cardiovascular

Chest Pain	☐Yes	☐ No
Palpitations	☐Yes	☐ No

Gastrointestinal

Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

Genitourinary

Blood in urine	☐Yes	☐ No
Change in urine Stream	☐Yes	☐ No
Urethral Discharge	☐Yes	☐ No

Hematopoietic/Lymphatic

Bruising Tendency	☐Yes	☐ No
Bleeding Tendency	☐Yes	☐ No
Swollen Lymph Glands	☐Yes	☐ No

Endocrine

Excessive Thirst	☐Yes	☐ No
Cold Intolerance	☐Yes	☐ No
Heat Intolerance	☐Yes	☐ No

Immunologic

Chemotherapy	☐ Yes	☐ No
High Dose Steroids	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No

Musculoskeletal

Back Pain	☐Yes	☐ No
Joint Pain	☐Yes	☐ No
Muscle Pain	☐Yes	☐ No

Skin

Rash	☐Yes	☐ No
Itching	☐Yes	☐ No

Neurologic

Numbness	☐Yes	☐ No
Tingling	☐Yes	☐ No
Headache	☐Yes	☐ No

Psychiatric

Anxiety	☐Yes	☐ No
Depression	☐Yes	☐ No
Suicidal	☐Yes	☐ No

_____

(Patient Initials)

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_____
(Date)

MRN #:
_____

MCKAY UROLOGY – LINCOLNTON OFFICE
PATIENT HISTORY FORM

PROSTATE SYMPTOM SCORE (AUASS) AND QUALITY OF LIFE (QOL)

Patient Name_____

Date_____

(Circle One Number on Each Line)	Not at All	Less Than 1 Time in 5	Less Than Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 or More Times**
Over the past month, how many times per night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add the score for each number above and write the total in the space to the right:

_____

Total:

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

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QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6