Center for Sexual & Urinary Function

Female and Male Medical History Questionnaire:

List **chronic health problems** you have or are currently treated for	Since	List any **Hospitalizations**	Date
1)		1)	
2)		2)	
3)		3)	
4)		4)	
5)		5)	
6)		6)	

List any **Surgeries**	Date	List any **Injuries**	Date
1)		1)	
2)		2)	
3)		3)	
4)		4)	
5)		5)	

List all drugs you presently use regularly or take occasionally

Medication	Strength	Dose
1)		
2)		
3)		
4)		
5)		
6)		

Allergies

Are you allergic to	List other allergies
☐ Penicillin	1)
☐ Sulfa drugs	2)
☐ Codeine or Morphine	3)
☐ Latex	4)
☐ Adhesive tape	
☐ Iodine (shellfish,contrast)	☐ no allergies known

Social history

Marital status
☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

Tobacco use
☐ Never
☐ Quit _____years ago
☐ Smoker
_____☐ cigarettes ☐ daily
☐ packs ☐ weekly

Alcohol Use in Past Year
☐ None, Enter number of
Occasion with >5 drinks ___
Drinks of typical occasion __
Drug Use……
☐ none

☐ < 2 drinks per month
☐ 2-4 times per month
☐ 2-3 times per week
☐ > times per week
☐ Quit _____ years ago
☐ Using now

Occupation ☐ Retired ☐ Disabled

Family History

Relative	Alive	Health	Died	Cause	Age	Relative	Alive	Health	Died	Cause	Age
Father	☐		☐			Sisters	☐☐☐		☐☐☐		
Mother	☐		☐			Sons	☐☐☐		☐☐☐		
Brothers	☐☐☐		☐☐☐			Daughters	☐☐☐		☐☐☐		

Is there family history of

☐ Cancer	☐ Diabetes	☐ Heart disease	☐ Kidney disease
☐ Prostate cancer	☐ Stroke	☐ Urinary abnormality	☐ Urinary stones

PATIENT NAME	**AGE**