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Medical History

Patient Name: _____ Birth Date: _____ Today's Date: _____

Briefly state the main and any secondary urologic problems for which you are seeing the doctor today:

VASECTOMY PATIENTS ONLY:

ages of children: _____ , _____ , _____ , _____ , _____ years married: _____ wife's age: _____

SYMPTOMS:

Kidney pain	Venereal disease/warts
Bladder pain	Urinary leakage with urgency
Pain during urination	Urinary leakage with moving, exercising, coughing, etc.
Urinary urgency	Slow urinary flow
Urinary frequency	Feeling of inadequate emptying
How often? _____	Known urinary infection
Excessive night urination	Swelling/lump/bulging in genital area
How often? _____	Urologic cancer (non-prostate)
Urinary bleeding	Other _____
Known urinary tract stones	

Men only

Impotency (poor erections)
Penile curvature
Other sexual problems
Ejaculation or libido issues
Cannot impregnate wife
Known prostate enlargement
Elevated PSA
Known prostate cancer

Women only

Vaginal pressure of prolapse
Significant GYN problems
(e.g. abnormal PAP)
GYN cancer
Chronic undiagnosed pelvic pain
Other _____

Elaborate on any of the above:

List all prior urologic (and gynecologic) surgeries and dates:

List any other surgeries and dates:

Patient Name: _____ Birth Date: _____ Today's Date: _____

MEDICAL CONDITIONS:

Heart disease
Heart attack
Stroke
High blood pressure
Cancers (Type: _____)

Diabetes
Chronic lung disease
GI problems/ulcers
Hepatitis
HIV

List any other significant medical diseases:

Do you currently use aspirin or any arthritis/anti-inflammatory drugs (e.g. Motrin)?: Yes No
Explain:

LIST ALL MEDICATION AND DOSAGES:

Medication Dose How often? Why?

Medication	Dose	How often?	Why?

List any allergic reactions to medications:

Have you smoked but quit? Yes No Packs per day? _____ # of years? _____

Do you still smoke? Yes No Packs per day? _____ # of years? _____

How much and what type of alcohol do you drink? _____

For how long? _____

What urologic diseases run in your family (blood relatives)?

What other diseases are in your family?

Are you having the following problems (review of systems)?

Fever, chills or night sweats Dizziness or fainting
Chest pain, shortness of breath Back pain, trouble walking
Chronic/productive cough Numbness or tingling
Change in bowel habits Loss of weight (_____ lbs.)
Bleed or bruise easily Poor appetite, nausea or vomiting
Anemia Skin rash
Feel weak or fatigue too easily Other _____

Signature: _____

Date: _____