Annual Health History

DATE: **PATIENT NAME**:

Medications and doses:____
____
____
____
____

Supplements, vitamins, herbs and over the counter medications: _____________________________________
____
____
____

Allergies:____

Last eye exam? ____________________________ **Last dental exam?** __________________________

Other doctors/practitioners that you have seen in the last year: ______________________________________

Emergency Room/Urgent care visits in the last year: ____

____

New medical problems in parents, brothers, sisters, children this year? ______________________________
____

Circle all that apply:

Recent illness fatigue fever weight loss

Change in vision headaches Cough shortness of breath

Chest pain palpitations lightheadedness

Heart burn difficulty swallowing diarrhea constipation abdominal pain

Urinary difficulties urgent urination incontinence erectile dysfunction prostate concerns

Pain in bones or joints

Do you wish to be tested for sexually transmitted disease____

In the past month have you often felt down, depressed or hopeless? _______

In the past month have you often been bothered by little interest or pleasure in doing things?_______

MEN:
Do you do a testicular self-exam? ________ Who in your family has had Prostate Cancer? ____________________________
If over 40, have you had prostate/rectal exam within the past year? ________ PSA blood test? ________________________
Please complete prostate symptom survey on the back of this page.

Do you wish testing for any sexually transmitted diseases? _____
If so, any specific ones? _________________________________

Patient signature: ____________________________________ **Reviewed by Doctor**: ______________________________

PLEASE FILL THIS OUT IF YOU ARE A MAN OVER 50 years of age.

Name: ____________________________________ **Date:** ____________

American Urological Association Symptom Score for Men with benign prostatic hyperplasia

During the past month or so, how often have you:	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
Had a sensation of not emptying your bladder after you finished urinating?	0	1	2	3	4	5
Had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
Stopped and started urinating several times during a single voiding?	0	1	2	3	4	5
Found it difficult to postpone urination?	0	1	2	3	4	5
Had a weak urinary stream?	0	1	2	3	4	5
Had to push or strain to begin urinating?	0	1	2	3	4	5
	None	1 time	2 times	3 times	4 times	>5 times
During the past month, how many times each night did you typically get out of bed to urinate? (Do not count the first urination after getting up in the morning).	0	1	2	3	4	5

Symptom score (sum of answers) ________________

< 3 no obvious prostatism 4-7 = Mild prostatism 8-18 = Moderate prostatism > 19 = Severe prostatism

	Delighted	**Pleased**	**Mostly satisfied**	**Mixed**	**Mostly dissatisfied**	**Unhappy**	**Terrible**
Quality of life due to urinary symptoms: If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Dec. 2011