

Fred Grossman M.D.

Urology and Male Sexual Dysfunction

MEDICAL HISTORY FORM

Please print and complete fully

NAME: _____ DATE: _____

BRIEFLY DESCRIBE THE REASON FOR THIS VISIT: _____

HAVE YOU HAD ANY OF THE FOLLOWING: (If YES, please explain)

NERVOUS DISORDER or STROKE Yes No _____

VISION PROBLEMS or BLINDNESS Yes No _____

HIGH BLOOD PRESSURE Yes No _____

HEART DISEASE Yes No _____

CHOLESTEROL or LIPID PROBLEM Yes No _____

BREATHING TROUBLE Yes No _____

INTESTINAL TROUBLE Yes No _____

URINATION, KIDNEY, PROSTATE PROBLEM Yes No _____

BONE, JOINT, OR BACK PROBLEM Yes No _____

CIRCULATION DEFICIENCY Yes No _____

JAUNDICE or LIVER DISEASE Yes No _____

ANEMIA or BLOOD DISEASE Yes No _____

DIABETES or OTHER GLAND DISEASE Yes No _____

CANCER Yes No _____

DEPRESSION or OTHER PSYCHOLOGICAL DISORDER Yes No _____

DO YOU PARTICIPATE IN SPORTS, EXERCISE, OR DAILY WALKS? Yes No (If YES, how often?) _____

HAVE YOU EVER HAD MAJOR SURGERY? Yes No (If YES, to surgery, what type and when?) _____

VASECTOMY? Yes No When? _____ Any Problem? _____

HAVE YOU EVER BEEN HOSPITALIZED OR TREATED FOR A MAJOR ILLNESS? Yes No (If YES, why and when?) _____

HAVE YOU EVER HAD AN ACCIDENT WITH MAJOR INJURY OR FRACTURES? Yes No (If YES, what type and when?) _____

PLEASE CONTINUE ON OTHER SIDE

MEDICAL HISTORY FORM – Pg. 2

LIST ALL MEDICATIONS YOU TAKE (include vitamins, birth control pills, aspirin, health food, etc.): Use additional sheet if needed.

Medication	Dose (mg)	How Often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DO YOU HAVE ANY ALLERGIES? Yes No (If YES, to what and what is your reaction?)

DO YOU USE TOBACCO? Yes No DETAILS: Cigarettes (how many and how long), cigars, pipe, chewing tobacco _____

DO YOU OR HAVE YOU USED ALCOHOL OTHER THAN SOCIALLY? Yes No (If YES, how much and what type?) _____

CURRENT OR PAST RECREATIONAL DRUG USE? (Narcotics, Marijuana, Cocaine, Heroin, others) Yes No

ARE YOU CURRENTLY MARRIED DIVORCED SEPARATED SINGLE, NEVER MARRIED (provide details)

OCCUPATION: (Past) _____

(Present) _____

FAMILY HISTORY:

	AGE	LIVING/DECEASED	STATE OF HEALTH/CAUSE OF DEATH
MOTHER	_____	_____ / _____	_____
FATHER	_____	_____ / _____	_____
BROTHERS	_____	_____ / _____	_____
	_____	_____ / _____	_____
SISTERS	_____	_____ / _____	_____
	_____	_____ / _____	_____
CHILDREN	_____	_____ / _____	_____
	_____	_____ / _____	_____

WHAT ILLNESSES RUN IN YOUR FAMILY? (diabetes, kidney stones, prostate or other cancer, bladder/kidney problems, etc.)

NOTES: (for office use only)