



# HILLCREST UROLOGICAL MEDICAL GROUP

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## *Medical History and Information*

### MEDICAL INFORMATION

PATIENT NAME		DATE OF BIRTH	AGE	TODAYS DATE
REASON FOR VISIT				
ALLERGIES TO MEDICATIONS				
MEDICATIONS	1.	2.	3.	4.
	5.	6.	7.	8.
	9.	10.	11.	12.
CHILDHOOD/ADULT MEDICAL PROBLEMS			PRIOR OPERATIONS	
PRIOR ANESTHESIA COMPLICATIONS <input type="checkbox"/> Yes <input type="checkbox"/> No				

### FAMILY HISTORY (Do you have a blood relative with any of the following?)

	YES	NO	WHO	WHAT TYPE
CANCER				
PROSTATE CANCER				
KIDNEY CANCER				
TUBERCULOSIS				
DIABETES				
HEART DISEASE				
HIGH BLOOD PRESSURE				
STROKE				
BLEEDING PROBLEMS				

### SOCIAL HISTORY

MARTIAL/ RELATIONSHIP STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Boyfriend/Girlfriend		
ALCOHOLIC BEVERAGES <input type="checkbox"/> Never <input type="checkbox"/> 1-3 drinks/month <input type="checkbox"/> 1/week <input type="checkbox"/> Daily	TOBACCO <input type="checkbox"/> Never <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Daily Packs per Day _____	
RECREATIONAL DRUGS <input type="checkbox"/> Never <input type="checkbox"/> 1-3 times/ month <input type="checkbox"/> 1/week <input type="checkbox"/> Daily	WHAT DRUG	HOW LONG
EMPLOYMENT <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Retired	WHAT IS YOUR JOB?	

### HEALTH STATUS QUESTIONNAIRE

**GENERAL**

Recent weight change Yes No  
 Fever or chills Yes No

**SKIN**

Skin disease Yes No  
 Jaundice Yes No  
 Hives or rash Yes No  
 Abnormal pigmentation Yes No

**HEAD, EYES, EARS, NOSE, THROAT**

Eye disease Yes No  
 Double vision Yes No  
 Glaucoma Yes No  
 Headaches Yes No  
 Nosebleeds Yes No  
 Ear disease Yes No  
 Impaired hearing Yes No  
 Dizziness Yes No

**RESPIRATORY**

Chronic cough Yes No  
 Asthma or wheezing Yes No  
 Difficulty breathing Yes No

**CARDIOVASCULAR**

Chest pain Yes No  
 Shortness of breath Yes No  
 Heart attacks Yes No  
 Heart murmur Yes No  
 High blood pressure Yes No  
 Ankle swelling Yes No

**GASTROINTESTINAL**

Ulcer Yes No  
 Gallbladder disease Yes No  
 Liver disease Yes No  
 Hepatitis Yes No  
 Diarrhea Yes No  
 Constipation Yes No  
 Blood in stool Yes No  
 Hemorrhoids Yes No  
 Bowel changes Yes No

**GYNECOLOGICAL**

Number of pregnancies \_\_\_\_\_  
 Number of miscarriages \_\_\_\_\_  
 Number of children \_\_\_\_\_  
 Ages \_\_\_\_\_

**MUSCULOSKELTEL**

Muscle weakness Yes No  
 Joint problems Yes No  
 Fractures Yes No  
 Difficulty walking Yes No  
 Back problems Yes No

**HEMATOLOGIC**

Blood disease Yes No  
 Anemia Yes No  
 Bleeding tendency Yes No  
 Abnormal bruising Yes No  
 Phlebitis Yes No  
 Blood clots Yes No

**UROLOGIC HEALTH QUESTIONS**

How often do you get up to urinate at night? 0 1 2 3 4 5 6 7 8 9 10

Are you presently sexually active? \_\_\_\_\_

Have you ever had a biopsy performed? \_\_\_\_\_

If you have had a biopsy performed what was biopsied? \_\_\_\_\_

When was the biopsy performed? \_\_\_\_\_ By Doctor \_\_\_\_\_

What is the date of your last complete physical examination? \_\_\_\_\_

At your last physical examination was there anything your practitioner noted as abnormal or concerning? \_\_\_\_\_ If yes what? \_\_\_\_\_

Have you had any of the following tests performed recently?

Test	Yes	No	When	Where	Value
CT					na
X-Ray					na
Lab test					na
PSA					