

Male Fertility and Sexual Medicine Specialists

MARTIN BASTUBA, M.D., F.A.C.S.

FOUNDER AND MEDICAL DIRECTOR

Date: _____

Name: _____ Age: _____ Ht: _____ Wt: _____

Main Complaint: _____ Referring Physician: _____

History of Main Complaint (Check “yes” or “no” where applicable):

1.) Do you have: a.) Blood in your urine? b.) Burning when you urinate? c.) Discharge	YES	NO	3.) Do you need to get to the toilet quickly when you need to urinate?	YES	NO
2.) How often do you urinate? a.) Urinate during the day (____ times) b.) Wake up at night to urinate (____ times)			4.) Do you leak urine/wet underwear? a.) When sneezing, coughing, laughing, or when exercising? b.) Anytime?	YES	NO

Urological History (Check “yes” or “no” where applicable):

5.) Have you had: a.) Previous urological treatment or tests? (i.e. cystoscopy) b.) Kidney stones? c.) Urinary tract infections? d.) Kidney/Bladder injuries? e.) Sexually transmitted diseases?	YES	NO	7.) (Men only) Are you able to get an erection?	YES	NO
			8.) (Women only) Is there a chance you might be pregnant?		
				9.) How many times have you been pregnant? _____	
	6.) Do you have sexual problems?		10.) How many vaginal births have you had? _____		

List all surgeries and medical illnesses you have had:

Past illnesses:	Year	Past Surgeries:	Year

List all known allergies to medicine and food:

Name of Allergy	Types of Reaction

Are You Allergic To: IODINE – Yes / No

Are You Allergic To: CONTRAST DYE – Yes / No

List ALL prescription, non-prescription, and herbal medications you are currently taking:

Name of Medication	Strength	Amount	Frequency	How Long?

FAMILY HISTORY:

Name	Age	Cause of death, if deceased or list serious illnesses
Father		
Mother		
Spouse (if married)		
Siblings/Children (list)		
1.)		
2.)		
3.)		

Is there any history of PROSTATE CANCER? YES / NO If so, Relationship: _____

PERSONAL HISTORY:

Occupation: _____ Birth date: ____ / ____ / ____ Marital Status: M S W D Sep.

Do you smoke? Y / N How long? _____ How many per day? _____ Past smoker? Y / N Quit date _____

Do you drink alcohol? Y / N Type? _____ How long? _____ How many per week? _____

Past drinker? Y / N Quit date? _____

Y	N	Constitutional	Y	N	Gastrointestinal	Y	N	Psychiatric
		Fatigue			Nausea or Vomiting			Anxiety
		Fevers			Diarrhea			Depression
		Loss of Appetite			Constipation			Moodiness
					Abdominal Pain			
					Jaundice or Hepatitis			
Y	N	Eyes	Y	N	Musculoskeletal	Y	N	Endocrine
		Eye Pain			Back Pain			Diabetes
		Loss or Blurring of Vision			Neck pain			Thyroid Disease
		Glaucoma			Joint or Pain Swelling			Weight Loss
Y	N	Cardiovascular	Y	N	Neurological	Y	N	Hematology
		Chest Pain			Paralysis			Bleeding Disorder
		Shortness of Breath with Exertion			Numbness			Easy Bruising
		Palpitations or Irregular Heartbeat			History of Stroke			Use of Aspirin, Coumadin, or other Blood Thinners.
		High Blood Pressure			Seizures			Past Blood Transfusions
		Heart Attack						
Y	N	Respiratory	<ul style="list-style-type: none"> ➤ All yes responses to above questions need to be thoroughly discussed with your primary care physician. A copy of this list is readily available upon request. ➤ Information from this form may be used with complete confidentiality for Urology research. 					
		Cough						
		Asthma						
		Sputum						
		Coughing Blood						

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Reviewed By: _____ Date: _____