

Name: _____
 Date of Birth: _____
 Referring Physician: _____
 Primary Care Physician: _____

Patient History Form
MURDOCK UROLOGY ASSOCIATES
 Myron I. Murdock M.D., F.A.C.S. Jonah D. Murdock M.D., Ph.D.
 (tel) 301-474-1111 (fax) 301-474-1151

Chief Complaint *Check the reason(s) for your visit below. Describe:*

Elevated PSA Difficulty with urination Blood in the urine Incontinence Erectile dysfunction
 Kidney stones Urinary tract infection Prostate cancer Bladder cancer Kidney cancer
 Abdominal pain Vasectomy Infertility Other: _____

HISTORY OF PRESENT ILLNESS

Location of the problem: _____
 When did you first notice it: _____
 How long does it last: _____
 Is it constant or variable: _____

Is there any other related problem: _____
 What helps the problem: _____
 What makes it worse: _____
 Rate how severe the problem is (10 is most severe):
 (circle) 1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY

Have you ever been treated for any of the following medical problems?
Circle Y or N, Also List Treating Doctor

Adrenal Problems	Y	N
Asthma/Emphysema	Y	N
Blood Clots	Y	N
Cancer: _____	Y	N
Cataracts	Y	N

Heart Disease/Failure	Y	N
Diabetes	Y	N
Gastrointestinal Bleed	Y	N
Glaucoma	Y	N
Gout	Y	N

Heart Attack/Stroke	Y	N
Hepatitis	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
HIV/AIDS	Y	N
Irregular Heart Beat	Y	N

Kidney Failure	Y	N
Kidney Stones	Y	N
Sleep Apnea	Y	N
Thyroid Disease	Y	N
Urinary Infection	Y	N
Other: _____		

PAST SURGICAL HISTORY ___ None

Have you ever had any type of surgery or procedure?

Surgery/Procedure	Date & Doctor
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS ___ None

List all prescription or over-the-counter medications you are taking now or have taken in the past month.

Medication	Dose & Prescribing Doctor
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES ___ No Allergies

Check below if allergic to any of the following

Penicillin Sulfa Latex
 Contrast Dye Iodine Seafood
 Other: _____

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SOCIAL HISTORY Circle Y or N

Do you currently smoke? Y N
Have you ever been a smoker? Y N
For how many years?
Do you drink alcohol? Y N
How many drinks per week?
Do you take any illegal drugs? Y N
Intravenous drugs? Y N
Occupation:
Employer:
Married Divorced Single
Number of Children Number of Pregnancies

FAMILY HISTORY Circle Y or N

Do you have any parents or siblings with any of the following conditions?
Prostate Cancer Y N
Kidney Stones Y N
Kidney Cancer Y N
Diabetes Y N
High Blood Pressure Y N
Other Cancers:
Other:

REVIEW OF SYSTEMS Do you now have or have you recently had any problems related to the following?

Circle Y or N

GENERAL SYMPTOMS

Tired/Sluggish Y N
Weakness Y N
Weight Gain/Loss Y N
Other:

EYES

Double Vision Y N
Glaucoma Y N
Blurred Vision Y N
Other:

EAR/NOSE/MOUTH/THROAT

Sinus Problems Y N
Ear Infections Y N
Persistent Headaches Y N
Other:

CARDIOVASCULAR

Chest Pain/Angina Y N
Palpitations Y N
Swollen Feet/Legs Y N
Other:

RESPIRATORY

Shortness of Breath Y N
Frequent Cough Y N
Wheezing Y N
Other:

VITAL SIGNS

Height: Weight:

SKIN

Skin Rash Y N
Persistent Itching Y N
Blisters/Boils Y N
Other:

NEUROLOGICAL

Dizziness Y N
Numbness/Tingling Y N
Tremors/Seizures Y N
Other:

BLOOD/LYMPHATIC

Blood Clots Y N
Swollen Glands Y N
Excessive Bleeding Y N
Other:

ENDOCRINE

Diminished Sexual Interest Y N
Too Hot/Too Cold Y N
Excessive Thirst Y N
Other:

GASTROINTESTINAL

Constipation Y N
Nausea/Vomiting Y N
Poor Appetite Y N
Other:

I certify that, to the best of my knowledge, the information on this form is complete and correct.

Patient Signature:

Date:

For Office Use:

Reviewed by Date Reviewed by Date

Reviewed by Date

Reviewed by Date