



CEDARS-SINAI MEDICAL CENTER.
Minimally Invasive Urology Institute

PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Age: _____ Date of Appointment: _____ Current Occupation: _____

If you are taking any medication, please list them below:

Current Medications	Dose
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Are you allergic to any medications? YES NO
 If yes, please list medication name(s) and reaction(s): _____

If you have ever had surgery before, please list below:

Type of Surgery	Date of Surgery
1. _____	_____
2. _____	_____
3. _____	_____

Have you ever taken Aspirin or blood thinning medications? YES NO
 If yes, explain why & when: _____

Have you ever had a heart attach? YES NO

Do you ever experience chest pain or angina? YES NO

Do you have any known heart disease or ailments?
 (murmurs, abnormal rhythm, etc.) YES NO

Patient Name: _____

MRN: _____

Do you have elevated blood pressure?

YES

NO

Have you ever been diagnosed with any lung disease?
(tuberculosis, emphysema, asthma, pneumonia, etc.)

YES

NO

Have you ever smoked cigarettes?

YES

NO

If yes, how much?: _____

Have you ever had a stroke?

YES

NO

Have you ever had diabetes?

YES

NO

Have you ever had hepatitis or liver disease?

YES

NO

Have you ever had stomach or duodenal ulcers?

YES

NO

Have you ever had back problems?

YES

NO

If yes, explain: _____

Have you ever had problems with vision?

YES

NO

(glaucoma, cataracts, etc.)

REVIEW OF SYSTEMS

Are you currently, or have you ever had, problems with:

General:

Fever

YES

NO

Weight Loss

YES

NO

Weight Gain

YES

NO

Excessive Fatigue

YES

NO

Night Sweats

YES

NO

Ear, Nose, Throat and Mouth:

Trouble Hearing

YES

NO

Sinus Problems

YES

NO

Sinus Headaches

YES

NO

Painful or Difficulty Swallowing

YES

NO

Mouth Sores

YES

NO

Cardiovascular:

Chest Pain or Angina(Date of Last EKG: _____) YES

NO

Palpitations

YES

NO

High Cholesterol

YES

NO

Shoulder Pain

YES

NO

Patient Name: _____

MRN: _____

Cardiovascular (cont'd):

- | | | |
|------------------------------------|------------------------------|-----------------------------|
| Buttock or Calf Pain with Exertion | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Swelling in Feet or Hands | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Leg Pain while Walking | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Respiratory:

- | | | |
|---------------------------------|------------------------------|-----------------------------|
| Chronic Cough | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Painful Breathing | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Shortness of Breath | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bronchitis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Lung Cancer | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bloody Sputum | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Date of Last Chest X-Ray: _____ | | |

Gastrointestinal:

- | | | |
|--------------------------|------------------------------|-----------------------------|
| Indigestion | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Nausea or Vomiting | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Weight Loss | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Blood in the Stool | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Liver Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Jaundice | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Abdominal Pain | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diarrhea or Constipation | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bleeding from the Rectum | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Appetite Disturbance | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Ulcers | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Gastritis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Genitourinary:

- | | | |
|--------------------------------------|------------------------------|-----------------------------|
| Urinary Tract Infections | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Painful or Burning w/Urination | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Blood in your Urine | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Leaking of Urine | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Frequent Urination | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Difficulty Starting Stream of Urine | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Difficulty Emptying Bladder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Waking to Urinate (how often): _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Incontinence | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Kidney Stones | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Prostate Cancer (males) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Endometriosis (females) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Uterine or Cervical Cancer (females) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Patient Name: _____

MRN: _____

Gynecologic:

- | | | |
|-------------------------------|------------------------------|-----------------------------|
| Menstrual Periods | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Regular? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Painful? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Abnormal Vaginal Bleeding | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Unusual Discharge | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Painful Intercourse | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Breast Swelling or Tenderness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Breast Masses | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Nipple Discharge | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Stone History:

Is this your first stone? YES NO

Is your current stone on the right or left side? RIGHT LEFT

How long have you known about this stone? _____

If you have had stones in the past, answer the following:

Total number of stones on the right side _____ left side _____ unknown _____

Number of stones passed spontaneously without intervention: right side _____ left side _____