LONG ISLAND
UROLOGICAL

TURHAN ILKAY M.D., F.A.C.S
ALTAN ILKAY M.D., F.A.C.S.

PATIENT HISTORY FORM

Name_____ Date__/___/____

Date of birth___/___/_____ Age ___ Occupation_____

Referring Physician_____Date of last exam_____

CHIEF COMPLAINT

WHY DID YOU COME TO THE DOCTOR TODAY?

_____

_____

_____

HISTORY OF PRESENT ILLNESS

WHEN DID IT BEGIN: _____
DESCRIBE PAIN (IF ANY)_____
IS IT GETTING WORSE: Yes No
IS IT ASSOCIATED WITH ANYTHING ELSE: _____

UROLOGICAL HISTORY

Have you ever seen blood in your urine? YES NO
Have you been told you have blood in your urine on a urine test? YES NO
Have you had kidney stones in the past? YES NO
If yes please list any treatment: _____
Have you had previous urinary tract infections (kidney/bladder): YES NO
IF YES: How many and when: _____
How were these infections treated? (list antibiotics used)

_____

How many times a night do you wake up to urinate?_____
How often do you urinate during the daytime? _____
Do you have pain or burning while passing urine? YES NO
Do you leak urine? YES NO

Do you leak urine at night or wet the bed? YES NO
Do you experience a strong urge to urinate that is difficult to control?
YES NO

Must you strain or push to urinate? YES NO
Do you have to wait awhile until the urinary stream begins? YES NO
Do you have a slow or dribbling stream? YES NO
Do you have back or flank pain? YES NO
Have you been seen in our office before or treated in the hospital? YES NO

MEN:
Do you experience any problems with erections? YES NO
Would you like any treatment or evaluation for erection problems? YES NO
Do you have poor or decreased sex drive? YES NO
Have you been treated by a urologist before? YES NO
If so, for what condition and when?_____

PAST MEDICAL & SOCIAL HISTORY

List any medication, herbs or supplements you take:

_____
_____
_____

List all past or present medical problems:
(example diabetes , heart disease, cancer, stroke, asthma)

_____
_____
_____\

List **ANY** surgeries and when they occurred:

_____
_____
_____

Do you have any allergies? YES NO if yes please explain

_____
_____

Do you smoke? YES NO if yes how much____ how long _____
Did you quit smoking? YES NO when ?_____
Do you drink? YES NO If yes, how much?_____
List any medical problems with you father/mother/siblings/uncle/aunt?
(any family history of cancer)

_____

REVIEW OF SYSTEMS

Do you have any problems related to the following symptoms? Circle Yes or No
Please explain any YES answers in the space provided

Constitutional Symptoms

Fever Y N
Chills Y N
Headache Y N
Other_____

Eyes
Blurred Vision Y N
Glaucoma Y N
Double Vision Y N
Other_____

Allergic/Immunological
Food Allergy Y N
Hay Fever Y N
Drug Allergy Y N
Other_____

Neurological
Tremors Y N
Seizures/Convulsions Y N
Dizzy spells Y N
Numbness/Tingling Y N
Stroke Y N
Other_____

Endocrine
Excessive Thirst Y N
Diabetes Y N
Too hot/cold Y N
Tired/sluggish Y N
Other_____

Gastrointestinal
Abdominal Pain Y N
Hepatitis Y N
Nausea/Vomiting Y N
Constipation Y N
Indigestion/heartburn Y N
Other_____

Gynecological
Last menstrual period_____
Abnormal menstrual period Y N
Pregnant Y N
Menopause Y N
Sexual problems Y N
Vaginal Bleeding Y N

Cardiovascular
Chest pain Y N
High Blood Pressure Y N
Heart Murmur Y N
Valve Replacement Y N
Stents Y N
Other_____

Skin
Skin rash Y N
Boils Y N
Persistent itch Y N
Other_____

Musculoskeletal
Joint Pain Y N
Joint replacement Y N
Neck Pain Y N
Back Pain Y N
Other_____

Ear/Nose/Throat/Mouth
Ear Infection Y N
Sore throat Y N
Sinus Problems Y N
Other_____

Respiratory
Asthma Y N
Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N
Other_____

Hematologic/Lympathic
HIV+ Y N
Swollen Glands Y N
Blood Clotting problem Y N
Other_____

Psychological
Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N
Other_____

Altan IlkayMD, FACS_____

Turhan Ilkay MD, FACS_____