JEFFREY L. MARKS, M.D., P.A., F.A.C.S.

Patient's Name: _____ Date: _____

We need to know your past medical history to best understand how we can help you. The information you give on this form will be kept confidential and will not be released unless you request us to do so in writing.

1. Briefly, why are you here to see the doctor?

_____

_____

_____

2. Have you ever been hospitalized?
   Yes □ No □

For what?	**When?**
_____	Mo. ____ Yr. _____
_____	Mo. ____ Yr. _____
_____	Mo. ____ Yr. _____
_____	Mo. ____ Yr. _____

3. Have you ever had any surgery?
   Yes □ No □

Procedure?	**When?**
_____	Mo. _____ Yr. _____
_____	Mo. _____ Yr. _____
_____	Mo. _____ Yr. _____
_____	Mo. _____ Yr. _____

4. List all medications you currently take.

_____

_____

_____

5. List all medications you are allergic to.

_____

_____

6. Have you ever been treated by an Urologist?
   Yes □ No □

Condition?	**When?**
_____	Mo. ____ Yr. _____
_____	Mo. ____ Yr. _____
_____	Mo. ____ Yr. _____
_____	Mo. ____ Yr. _____

7. Please list all physicians currently caring for you.

Physician?	**Condition?**
_____	_____
_____	_____
_____	_____
_____	_____

8. **The following apply to female patients only:**

Are you pregnant? _____ Is intercourse painful? _____

Are you having vaginal discharge? _____ Last menstrual period? _____

Last birth control, if any. _____

9. Please check any of the following conditions you may have or have been treated for in the past:

Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Heart murmur
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	High blood pressure	☐	☐	Seizures
☐	☐	Irregular heart rate	☐	☐	Cancer
☐	☐	Angina	☐	☐	U.T.I.'s
☐	☐	Circulatory problems	☐	☐	Kidney stones
☐	☐	Bleeding disorders			

10. Please check if you are presently having any of the following symptoms.

Yes	No		Yes	No	
☐	☐	Blood in urine	☐	☐	Abdominal pain
☐	☐	Blood on underwear	☐	☐	Flank pain
☐	☐	Burning on urination	☐	☐	Groin pain
☐	☐	Frequency of urination	☐	☐	Pain in genital area
☐	☐	Urinary incontinence	☐	☐	Bedwetting
☐	☐	Urgency	☐	☐	Loss of appetite
☐	☐	Getting up at night to void	☐	☐	Loss of weight
☐	☐	Straining to void			

Smoking: ☐ Never ☐ Quit: ___ Years ago ☐ 0-1 pks/day ☐ 2 pks/day ☐ 3 or more pks/day

Alcohol: ☐ Never ☐ Rare ☐ Occasional ☐ Social ☐ Moderate ☐ Heavy