RIVERSIDE UROLOGY, INC.

Herbert W. Riemenschneider, M.D.
Michael C. Sweeney, M.D.

MEDICAL HISTORY FORM

NAME _____ DATE _____ AGE _____ WEIGHT _____

1. Have you recently been in an emergency room? _____ When? _____ Where? _____
2. Have you had x-rays of your kidneys taken? _____ When? _____ Where? _____
3. Did you have any bladder or kidney problems as a child? Yes _____ No _____
4. Why are you here to see the doctor? (What is your problem?)_____
   _____
   _____
5. How long have you had this trouble? _____
6. Are you having or recently had any of the following symptoms? Please answer "yes" or "no".
   a. _____ Frequency (going to the bathroom often)
   b. _____ Dysuria (burning or painful urination)
   c. _____ Nocturia (getting up at night to void)
   d. _____ Urgency (having to go in a hurry)
   e. _____ Hematuria (blood in the urine)
   f. _____ Bladder pain (lower abdominal)
   g. _____ Back pain
   h. _____ Incontinence (loss of urine involuntarily)
   i. _____ Urethral discharge
   j. _____ The feeling of not completely emptying your bladder
7. Have you ever passed a kidney stone? Yes _____ No _____
8. Have you ever had V.D.? Yes _____ No _____
9. List all allergies or medicines you cannot take and the type of reaction:
   a. _____ b. _____ c. _____ d. _____
10. List all the medications you are presently taking:
    a. _____ b. _____ c. _____ d. _____
11. List kind and date of all operations you have had:
    a. _____ b. _____ c. _____ d. _____
12. Name and dates of all serious medical illness or hospitalizations:
    a. _____ b. _____ c. _____ d. _____
13. Answer the following "yes" or "no"

_____ dizzy spells	_____ thrombophlebitis (blood clot in vein)
_____ shortness of breath	_____ heart murmur
_____ recurrent chest pain	_____ rheumatic fever
_____ asthma	_____ easy bruising or bleeding
_____ emphysema	_____ diabetes
_____ presently smoke	_____ jaundice (liver disease)

14. **Women only**
    a. Date of last menstrual period _____
    b. Number of children _____
    c. Type of birth control _____
    d. Date of last cancer PAP smear _____
    e. Vaginal discharge? Yes _____ No _____