Medical history

Surname, first name: _____ Date of birth: _____

Marital status: _____ Profession: _____

Height: _____ Number of children: _____

Weight: _____ Phone: _____

Adress: _____ Email: _____

How did you hear about us? _____

Why are you coming to us? _____

Are there familial tumors or chronic diseases? _____

Do you smoke? yes ◯ no ◯

Do you drink alcohol? yes ◯ no ◯ What, how much? _____

Do/did you suffer from non-urological diseases (if applicable, when?)

no ◯

yes ◯	Diabetes mellitus (sugar)	yes ◯	Liver disease
yes ◯	Fat metabolism disorder	yes ◯	Kidney disease
yes ◯	Glaucoma (increased intraocular pressure)	yes ◯	Gout
yes ◯	Bluthochdruck	yes ◯	Infectious diseases
yes ◯	Angina pectoris	yes ◯	Tuberculosis
yes ◯	Circulatory disorder	yes ◯	Bronchial asthma
yes ◯	Other heart diseases	yes ◯	Parkinson`s disease
yes ◯	Stroke	yes ◯	Multiple sclerosis
yes ◯	Thyreoid disease	yes ◯	Cancer, which one?

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Do you have other illnesses (Orthopaedics/Arthrosis/pain...)? _____

Do you take any medication (blood thinners, vitamins...)? yes ◯ no ◯

Do you have allergies (drug or contrast medium intolerance)? yes ◯ no ◯

Have operations been done? _____ yes ◯ no ◯

What urological diseases do you have/did you have and when (stones, infextions, tumors...)?

How strong is your urinary stream? weak ◯ medium ◯ strong ◯

How often do you urinate? day: _____ at night: _____

Was there blood in the urine? yes ◯ no ◯

Are you losing urine? yes ◯ no ◯

Bowel movement: regularly ◯ irregular ◯ with ◯

Colonoscopy done? yes ◯ when: _____ no ◯

As a man, do you suffer from a erectile dysfunction? never ◯ occasionally ◯ often ◯ always ◯

As a woman, are you pregnant? yes ◯ no ◯

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