DATE:___/___/20___

MALE PATIENT GU HISTORY FORM

PATIENT NAME:_____ DOB: _____

DO YOU HAVE, OR HAVE YOU RECENTLY HAD, ANY OF THE FOLLOWING SYMPTOMS?
(PLEASE CIRCLE YOUR RESPONSE):

BEDWETTING?	YES	NO
BLOOD IN THE SEMEN (WITH EJACULATION)?	YES	NO
BLOOD IN THE URINE?	YES	NO
DAYTIME WETTING OF CLOTHES?	YES	NO
DIFFICULTY WITH GETTING OR KEEPING AN ERECTION?	YES	NO
DISHARGE OR PUS FROM THE URETHRA/PENIS?	YES	NO
EXCESSIVE DRIPPING OF URINE AT THE END OF URINATION?	YES	NO
FERTILITY PROBLEM?		
HISTORY OF SEXUALLY TRANSMITTED DISEASE (STD, VD, Herpes, Gonorrhea, Chlamydia, etc.)?	YES	NO
HISTORY OF UNDESCENDED TESTICLE?	YES	NO
KIDNEY INFECTON (PYELONEPHRITIS)?	YES	NO
LOSS OF URINE (LEAKAGE, INCONTINENCE) WITH COUGHING OR SNEEZING?	YES	NO
PAIN OR BURNING WITH URINATION?		
PAIN WITH SEXUAL INTERCOURSE OR WITH EJACULATION?	YES	NO
PAINFUL OR SWOLLEN TESTICLES?	YES	NO
SKIN PROBLEMS/RASH IN THE GROIN/GENITAL AREA?	YES	NO
STONES IN THE KIDNEY OR BLADDER (NOT gallbladder)	YES	NO
URINARY TRACT INFECTION (UTI, BLADDER INFECTION)?	YES	NO