Urologie Friedrichstraße
Dr. med. C. Schurwanz & Dr. med. K.- U. Johann & Dr. med. S. Ruppin
Friedrichstr. 94, 10117 Berlin

Name:	**Date of birth:**	**Marital status:**	
Occupation:	**Number of children:**	**Weight (kg):**	**Height (cm):**
Do you smoke? ☐ Never Yes: ☐ Until: ☐ How many/day:	**Alcohol consumption:** Never ☐ Regular ☐ Please specify:		
Please describe your present problems!	**How did you find our office?**		

Date: Signature:

Do you suffer from any NON-UROLOGICAL disease? **No** ☐			
Diabetes	Yes ☐	Fat metabolism disorder	Yes ☐
Glaucoma	Yes ☐	High blood pressure	Yes ☐
Angina pectoris	Yes ☐	Other heart diseases	Yes ☐
Circulatory disorder	Yes ☐	Stroke	Yes ☐
Thyroid disease	Yes ☐	Liver disease	Yes ☐
Kidney disease	Yes ☐	Gout	Yes ☐
Infectious diseases	Yes ☐	Tuberculosis	Yes ☐
Bronchial asthma	Yes ☐	Parkinson's disease	Yes ☐
Multiple Sclerosis	Yes ☐	Cancer	Yes ☐
Other diseases?			

What medication / vitamines do you take regularly or are you currently taking?	
None ☐	1.
2.	3.
4.	5.
6.	7.

Do you have any allergies or intolerances? Please specify:		
No ☐	Yes ☐	1.
2.		3.
4.		5.

Have you had any surgery carried out in hospital?		
No ☐	Yes ☐	1.
2.		3.
4.		5..

How often do you have to urinate?		**Do you suffer from incontinence?**	Yes ☐ No ☐
Daytime:	Night:	**Have you found any blood in your urine?**	Yes ☐ No ☐

How strong is your urinary stream? Weak ☐ Moderate ☐ Strong ☐
Do you have or had any UROLOGICAL diseases (kidney stones, infections, tumours…)?

For men: Do you have any problems with the erectile function?			
Never ☐	Sometimes ☐	Often ☐	Always ☐
Defecation:	Regularly ☐	Irregularly ☐	With blood ☐
Have you had a coloscopy?		No ☐	Yes ☐, when?