UROLOGY SPECIALISTS, P.C.

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. This information will not be released to anyone without your authorization.

Today's Date: **Date of Birth:**

Name *(Last, First, M.I.)*:

Reason for visit/Chief Complaint:

Physician use only

PAST MEDICAL HISTORY

Please list All prior surgeries

Date	Surgery	Date	Surgery

Please list all past and current medical conditions

Date Diagnosed	Medical Condition	Date Diagnosed	Medical Condition

List your prescribed and over-the-counter drugs, including vitamins

Name of Drug	Strength	Frequency Taken

Allergies

Name of Drug	Reaction

Patient Name: **Date of Birth:**

SOCIAL HISTORY

Personal	Marital Status (circle one): Single / Married / Divorced / Separated / Widowed		
	Please list number of children and their ages:		
	What is your religious affiliation, if any? Do you live alone?	☐ Yes	☐ No
	What is your primary language? Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advanced Directive or Living Will?	☐ Yes	☐ No
Alcohol	Do you drink alcohol? ☐ Yes ☐ No If Yes, what kind & how many drinks/week?		
Tobacco	Do you smoke? ☐ Yes ☐ No If Yes, how many packs/day?		
	☐ # of years ☐ If you quit, when? (year)		
Drugs	Do you currently or have you used recreational or street drugs?	☐ Yes	☐ No

FAMILY HISTORY

Does anyone in your family have a history of any of the following: *(Please circle all that apply):*

Kidney Stones	Adrenal Cancer	Urinary Tract Infections	Diabetes	Thyroid Disease
Kidney Cancer	Bladder Cancer	Heart Problems	Tuberculosis	Bleeding Disorders
Kidney Disease	Prostate Cancer	High Blood Pressure	Alcoholism	Anesthesia Problems
Polycystic Kidneys	Testicular Cancer	Lung Problems	Strokes	***None Apply***

Other Cancer (specify): ______________________

REVIEW OF SYSTEMS

Do you now have or have you had any of the following?

Fever/ Chills	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No	Artificial joint	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Latex allergy	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No
Recent productive cough	☐ Yes	☐ No	Previous blood transfusion	☐ Yes	☐ No
Exposure to tuberculosis	☐ Yes	☐ No	Skin rash	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	Excessive thirst	☐ Yes	☐ No
Abnormal blood pressure	☐ Yes	☐ No	Decreased sex drive	☐ Yes	☐ No
Ankle swelling	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No	Feel depressed	☐ Yes	☐ No
Artificial heart valve	☐ Yes	☐ No	Considering suicide	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No	Abdominal pain	☐ Yes	☐ No
Leaking urine	☐ Yes	☐ No	Nausea/Vomiting	☐ Yes	☐ No
Frequent urinary infections	☐ Yes	☐ No	Constipation	☐ Yes	☐ No
Blurred vision	☐ Yes	☐ No	Ulcer disease	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Dizzy spells	☐ Yes	☐ No
Paralysis/weakness	☐ Yes	☐ No	Numbness	☐ Yes	☐ No
New back pain	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Are you required to take antibiotics with dental work?	☐ Yes	☐ No			

Immunization History:						
	Tetanus	☐ Yes	☐ No	Flu Shot	☐ Yes	☐ No
	Pneumovax	☐ Yes	☐ No	Other:______________	☐ Yes	☐ No

For Doctor Use Only (sign/date) ______________________ ______________________ ______________________

______________________ ______________________ ______________________ ______________________

Patient Name: **Date of Birth:**

FEMALE HEALTH INVENTORY		
Age at onset of menstruation:		
Have you undergone menopause?	☐ Yes	☐ No
If no, date of last menstruation:		
Number of pregnancies _____ Number of live births _____ Number of vaginal deliveries________		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any frequency of urination?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
If yes, do you leak urine with coughing, sneezing, or vigorous activity?	☐ Yes	☐ No
If yes, do you leak urine due to a sudden feeling of urgency?	☐ Yes	☐ No