

# 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:

## 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**

<b>Personal</b>	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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	What is your primary language?	Do you have vision or hearing loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have an Advanced Directive or Living Will?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Alcohol</b>	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what kind & how many drinks/week?		
<b>Tobacco</b>	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how many packs/day?		
	<input type="checkbox"/> # of years <input type="checkbox"/> If you quit, when? (year)		
<b>Drugs</b>	Do you currently or have you used recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> 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      | <b>None Apply</b>   |

Other Cancer (specify): \_\_\_\_\_

**REVIEW OF SYSTEMS**

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

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

Are you required to take antibiotics with dental work?  Yes  No

**Immunization History:**

Tetanus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flu Shot	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumovax	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**For Doctor Use Only (sign/date)** \_\_\_\_\_

Patient Name:

Date of Birth:

**FEMALE HEALTH INVENTORY**

Age at onset of menstruation:		
Have you undergone menopause?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, date of last menstruation:		
If no, do you have heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any frequency of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, do you leak urine with coughing, sneezing, or vigorous activity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, do you leak urine due to a sudden feeling of urgency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		