Urologic Specialists

PATIENT HISTORY FORM

Today's Date: _______________
Patient Name:_________________________________ **Date of Birth:**____________ **Age:**________
Primary Care Physician:______________________ **Referring Physician:**_______________________
What Pharmacy do you use? (Name, Location, and Phone Number):______________________________

____

Do we have consent to import your medication list from your pharmacies? YES_____ NO_____
Are you living in a skilled nursing facility? If so, please list Name, Location, and Phone Number.:_____

____

Chief Complaint:____

(reason for visit)

Your Past Medical History:
(circle all personal medical problems)

High Blood Pressure	**Y**	**N**	**Cancer**	**Y**	**N**
Diabetes	**Y**	**N**	**Bowel Disease**	**Y**	**N**
Heart Disease	**Y**	**N**	**Eye Disease**	**Y**	**N**
Heart Attack	**Y**	**N**	**Cataracts**	**Y**	**N**
Irregular Heart Beat	**Y**	**N**	**Skin Problems**	**Y**	**N**
Stroke	**Y**	**N**	**Psychological Problems**	**Y**	**N**
Arthritis / Joint Disease	**Y**	**N**	**Gout**	**Y**	**N**
Liver Disease	**Y**	**N**	**Thyroid Disease**	**Y**	**N**
Lung Disease	**Y**	**N**	**Gynecologic Disease**	**Y**	**N**

OTHER:____

Do you currently see other specialist doctors (e.g. cardiologist, gastroenterologist, etc?) **Y N**
If yes, who? ____

Have you ever been treated for any type of cancer? Y N
If yes, what kind and when? ____

Past Surgical History:
(List all surgery and dates of surgery, e.g., hernia , gall bladder, bowel, heart, joints,
vasectomy, hysterectomy, angioplasty, all biopsies, bladder, prostate, uterus, ovaries)

____

____

Have you ever had a colonoscopy? Y N **Date of last colonoscopy:** ____________________

Medications:
(please provide a copy of your medications list or write below all medications and their doses including both
prescription and over the counter medications, e.g., Aspirin, Advil, Antihistamines, Herbs, Supplements…)

____

____

Have you had a pneumonia vaccine? Y N **Date of vaccine:** ______________________

Allergies (medications, contrast, latex…)**:** ____

Have you ever been exposed to or worked with chemicals over a long period time?: Y N
If yes, what kind? ____

Family History (list all medical problems in your immediate family - grandparents, parents,
siblings, children) ____
Has anyone in your family had (circle): Prostate cancer? Bladder cancer? Kidney cancer?

If yes, who? ____

PLEASE COMPLETE BACK OF THIS FORM

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Patient Name:______________________________ Date of Birth:____________

SOCIAL HISTORY: Married ____ Single ____ Divorced ____ Widowed ____ Separated ____

Past or present occupation: ____________________________________Retired? Y N

Are you smoking now? Y ____ N ____ How much per day? _________________

Did you ever smoke? Y ____ N ____ When did you quit? __________________

How long did(have) you smoke(d)? ______________________________________

Do you drink alcohol? Y ____ N ____ How much per day? __________________

How many caffeinated drinks do you have each day? _______________________

Have you ever had a blood transfusion? __________________________

Review of Systems

(Do you have any of the following symptoms? If yes, explain to the right)

Constitutional:

Fever Y ____ N ____
Chills Y ____ N ____
Weight loss Y ____ N ____
Weight gain Y ____ N ____

Eyes:

Cataracts Y ____ N ____
Blurry vision Y ____ N ____
Double vision Y ____ N ____

Ear/Nose/Throat:

Hearing loss Y ____ N ____
Nasal stuffiness Y ____ N ____
Sore throat Y ____ N ____

Cardiovascular:

Irregular heartbeat Y ____ N ____
Chest pain Y ____ N ____
Heart attack Y ____ N ____
Heart murmur Y ____ N ____
Hypertension Y ____ N ____
Swollen ankles Y ____ N ____

Respiratory:

Short of breath Y ____ N ____
Wheezing Y ____ N ____
Emphysema Y ____ N ____
Chronic cough Y ____ N ____

Gastrointestinal:

Abdominal pain Y ____ N ____
Stomach ulcers Y ____ N ____
Reflux Y ____ N ____
Jaundice Y ____ N ____
Nausea / vomiting Y ____ N ____
Change in bowels Y ____ N ____

Genitourinary:

Incontinence Y ____ N ____
Painful urination Y ____ N ____
Blood in urine Y ____ N ____

Musculoskeletal:

Arthritis Y ____ N ____

Skin:

Rash Y ____ N ____
Persistent itching Y ____ N ____
Skin cancer Y ____ N ____

Neurologic:

Stroke Y ____ N ____
Dizziness Y ____ N ____
Weakness Y ____ N ____
Numbness Y ____ N ____
Tingling Y ____ N ____

Endocrine:

Thyroid disease Y ____ N ____
Diabetes Y ____ N ____

Hematologic:

Anemia Y ____ N ____
Abnormal bleeding Y ____ N ____
Swollen glands Y ____ N ____
Blood transfusion Y ____ N ____

Cancer:

Bladder Y ____ N ____
Prostate Y ____ N ____
Breast Y ____ N ____
Other Y ____ N ____

Penile: (Male Patient's Only)

Is there a lump, bump, and/or curve in your erection?

Bump Y ____ N ____
Lump Y ____ N ____
Curve Y ____ N ____

If YES, when did your symptoms start?

Past month? ______
Past 6 months? ______
Past year? ______
Longer than 1 year? ______

Chronic back pain Y ____ N ____
Chronic neck pain Y ____ N ____
Sore muscles Y ____ N ____

Please initial here: ___________