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_____

Chief Complaint (reason for visit):_____
_____

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

Arthritis / Joint Disease	**Y**	**N**	**Heart Problems**	**Y**	**N**
Bleeding Problems	**Y**	**N**	**Kidney Disease**	**Y**	**N**
Cancer	**Y**	**N**	**Lung (breathing problems)**	**Y**	**N**
Diabetes	**Y**	**N**	**Neurological & Development Problems**	**Y**	**N**
Frequent Infections	**Y**	**N**			

If yes, explain: _____
OTHER:_____
_____

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

Past Surgical History: (List all surgery and dates of surgery, e.g., tonsillectomy, appendectomy, hernia)

Date	Type/Reason	Surgeon/Physician	Hospital

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…)

_____
_____
_____

Allergies (medications, contrast, latex…)**: _____**
Has the patient ever had a reaction to iodine x-ray dye? ____YES ____NO
If yes, what type of reaction? _____

Family History:
(Please note the immediate family (Parents, Siblings & Grandparents) & Maternal (M) or Paternal (P) when appropriate)

Arthritis: _____ **Kidney Disease or Stones: _____**
Cancer: _____ **Lung Disease: _____**
Diabetes: _____ **Neurological Problems: _____**
Heart Disease: _____ **Strokes: _____**
High Blood Pressure: _____ **Tuberculosis: _____**
OTHER: _____

PLEASE COMPLETE BACK OF THIS FORM

Urologic Specialists

Patient Name:_____ **Date of Birth:**_____

BIRTH DEVELOPMENT & SOCIAL HISTORY:

Was the patient full-term at birth? ____YES ____NO
Were there any complications during pregnancy or birth of the child? ____YES ____NO
If Yes, please explain _____
What was the patients birth weight? _____
How many caffeinated drinks does the patient have each day? _____
Is the patient up to date on childhood immunizations? ____YES ____NO
Has the patient ever had a blood transfusion? ____YES ____NO
Has the patient ever had x-rays (IVP or Ultrasound) performed? ____YES ____NO

Review of Systems: (Does the patient have any of the following symptoms?)

Constitutional:
- Fever Y ____ N ____
- Chills Y ____ N ____
- Abnormal growth Y ____ N ____
- Abnormal development Y ____ N ____

Eyes:
- Blurry Vision Y ____ N ____
- Redness Y ____ N ____
- Pain Y ____ N ____

Ear/Nose/Throat/Mouth:
- Ear infections Y ____ N ____
- Sore throat Y ____ N ____
- Sinus problems Y ____ N ____

Allergies:
- Hay fever Y ____ N ____
- Drug allergies Y ____ N ____
- Food allergies Y ____ N ____

Respiratory:
- Short of breath Y ____ N ____
- Wheezing Y ____ N ____
- Chronic cough Y ____ N ____

Gastrointestinal:
- Abdominal pain Y ____ N ____
- Constipation Y ____ N ____
- Nausea / vomiting Y ____ N ____

Musculoskeletal:
- Joint pain Y ____ N ____
- Chronic back pain Y ____ N ____
- Muscle Cramping Y ____ N ____

Kidney/Bladder:
- Blood in urine Y ____ N ____
- Burning w/ urination Y ____ N ____
- Frequent urination Y ____ N ____
- Weak, dribbling stream or trouble starting a stream (poor force) Y ____ N ____
- Wetting the bed at night? Y ____ N ____
- Daytime wetting of clothes? Y ____ N ____
- Leakage of uring if he/she does not get to the restroom immediately? Y ____ N ____

Skin:
- Rash Y ____ N ____
- Persistent itching Y ____ N ____
- Easy Bruising Y ____ N ____

Neurologic:
- Seizures Y ____ N ____
- Abnormal walking Y ____ N ____
- Abnormal coordination Y ____ N ____

Cardiovascular:
- Heart murmer Y ____ N ____
- Hypertension Y ____ N ____

Hematologic:
- Anemia Y ____ N ____
- Abnormal bleeding Y ____ N ____
- Swollen glands Y ____ N ____
- Prostate Y ____ N ____
- Breast Y ____ N ____
- Other Y ____ N ____

Hormone system:
- Excessive thirst Y ____ N ____
- Tired/Sluggish Y ____ N ____
- Abnormal hair growth Y ____ N ____

Blood/Lymph glands:
- Swollen glands Y ____ N ____
- Blood clotting Y ____ N ____

History to urinary tract infections? **Y ____ N ____**

If yes, explain: _____

OTHER:_____