Urologic Specialists

PATIENT HISTORY FORM

Please fill out completely

Today's Date: _____
Patient Name:_____ Date of Birth:_____ Age:_____
Primary Care Physician:_____ Referring Physician:_____

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)

_____
_____

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…)**:** _____
Have you ever been exposed to or worked with chemicals over a long period of time? 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

Urologic Specialists

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

Please initial here: _____

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 _**