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 ti 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 ____
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 ____

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?	______