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):_____

_____

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

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 ____
- **History to urinary tract infections?** 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 ____

If yes, explain:
OTHER:_____