

Urology Center, P.C.

Patient History Form

Date: _____

Date of Birth: _____

Name: _____

Age: _____

Past Medical History

Please check any illnesses you have or have had in the past:

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Artrial Fibrillation | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Neurogenic Bladder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Degenerative Lumbar Disk Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Benign Prostatic Hypertrophy (BPH)
or Enlarged Prostate | <input type="checkbox"/> Dementia/Alzheimers | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Depression | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Bleeding Tendency Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Cancer – Bladder | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Cancer – Breast | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Cancer – Cervical | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Radiation Cystitis |
| <input type="checkbox"/> Cancer – Colon | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Renal Insufficiency |
| <input type="checkbox"/> Cancer – Esophageal | <input type="checkbox"/> GERD/Acid Reflux | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cancer – Kidney | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Spina Bifida or
Myelomeningocele |
| <input type="checkbox"/> Cancer - Leukemia/Lymphoma | <input type="checkbox"/> Gout | <input type="checkbox"/> STD |
| <input type="checkbox"/> Cancer – Lung | <input type="checkbox"/> Heart Attack/MI | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer – Other | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer – Prostate | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Transient Ischemic Attack |
| <input type="checkbox"/> Cancer – Skin | <input type="checkbox"/> High Blood Pressure/Hypertension | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer – Testicular | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Urethral Stricture Disease |
| <input type="checkbox"/> Cancer – Uterine | <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Valvular Heart Disease or
Heart Murmur |
| <input type="checkbox"/> Cardiac Arrhythmia | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Irritable Bowel Syndrome | |
| <input type="checkbox"/> Chron's/Ulcerative Colitis | <input type="checkbox"/> Kidney Infection | |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Kidney Stones | |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Liver disease/Jaundice | |
| | <input type="checkbox"/> MRSA | Other: _____ |

Past Surgical History

Please list all of your previous operations and hospitalizations. Give dates and locations if known.

If female, how many pregnancies have you had? _____ How many miscarriages? _____

Family History

Please check each medical concern that has occurred in your blood relatives:

DISEASE	Father	Mother	Sister	Brother		Father	Mother	Sister	Brother
Diabetes					High Blood Pressure				
Kidney Disease					Heart Disease				
Kidney Stones					Bedwetting				
Cancer					Nervous Disorder				
Bleeding Tendency					Stroke				
					Tuberculosis				

Is your father alive? ___ Yes ___ No Age/Age at death: ___ Present Health/Cause of Death _____

Is your mother alive? ___ Yes ___ No Age/Age at death: ___ Present Health/Cause of Death _____

If you are a male, do you have any relatives who have had prostate cancer? ___ Yes ___ No

If so, which relatives? ___ Father ___ Brother(s) ___ Other _____

If you know of any other medical conditions that run in your family, please list them here:

Name: _____

Social Habits History

Do you smoke cigarettes? ___ Yes ___ No If yes, how many packs per day? ___ For how long? _____

Did you smoke cigarettes previously and quit? ___ Yes ___ No If yes, how many packs per day? ___ For how long? _____ When did you quit? _____

Do you use any other form of tobacco? ___ Yes ___ No If yes, what kind? _____

Do you drink alcohol? ___ Yes ___ No If yes, how much do you drink in an average week? _____

Do you drink caffeine? ___ Yes ___ No If yes, how many per day? _____

Do you use any other drugs? ___ Yes ___ No If yes, what kind? _____

Allergies

Please list your allergies and your reactions to those allergies: _____ None

<u>Medication</u>	<u>Reaction</u>	<u>Medication</u>	<u>Reaction</u>
___ Sulfa	_____	Other: _____	_____
___ Penicillin	_____	Other: _____	_____
___ Iodine (IV Contrast/Dye)	_____	Other: _____	_____
___ Latex	_____	Other: _____	_____
Other: _____	_____	Other: _____	_____
Other: _____	_____	Other: _____	_____

Other (Please Specify): _____

Medications

Please list all of the medications you are currently taking, including nonprescription drugs:

- | | |
|------------------------------------|---|
| ___ Aspirin | List Medications Here:

_____ |
| ___ Blood Thinners (e.g. coumadin) | |
| ___ Steroids (e.g. prednisone) | |
| ___ Insulin | |
| ___ Glucophage | |
| ___ Nitrates (e.g. nitroglycerin) | |

Please attach your medication list if there is not enough space.

Your local Pharmacy: _____

Your mail order Pharmacy: _____

Please bring your current medication list to every visit to The Urology Center PC

Chief Complaint

What is the main reason you came to the Urology Center at this time? _____

Name: _____

Date of Birth: _____

Urologic Symptoms

Please check symptoms you have now:

- | | |
|---|--|
| <input type="checkbox"/> blood in urine | <input type="checkbox"/> incontinence |
| <input type="checkbox"/> burning or pain with urination | <input type="checkbox"/> phimosis |
| <input type="checkbox"/> change in voiding habits | <input type="checkbox"/> slow urinary stream |
| <input type="checkbox"/> dysuria | <input type="checkbox"/> stress incontinence |
| <input type="checkbox"/> flank pain | <input type="checkbox"/> trouble starting stream |
| <input type="checkbox"/> frequent urination - daytime | <input type="checkbox"/> trouble with erections |
| <input type="checkbox"/> frequent urination - night | <input type="checkbox"/> urethral discharge |
| <input type="checkbox"/> incomplete bladder emptying | <input type="checkbox"/> urgency |
| | <input type="checkbox"/> vaginal discharge |

Review

Reviewed by: _____ **M.D.** **Date:** _____

