Patient History Form

THE UROLOGY GROUP
Advanced Care. Improving Lives.

Do not fill out this form unless instructed by the office. Staff will call for this information.

Acct#_____ **MD**_____

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Family or Referring Doctor:_____

Pharmacy:_____ Pharmacy #_____ Appointment Date:_____

HISTORY OF PRESENT ILLNESS

CHIEF COMPLAINT (What is the main reason for your visit today?)_____

_____

_____

Date of onset:_____ List location (left or right):_____

Any Test? What type?_____

_____

Blood in Urine? Y / N
Color of Urine? Bright Red____, Pink____,
Dark Red____, Clear____, Microscopic____
Clots in Urine? Y / N
Frequent Urination Y / N
How Often? Every _____ hours
Nocturia? (Urinating at night) Y / N
How Often? _____ times a night

Slow or weak stream? Y / N
Burning with Urination? Y / N
Leaking of Urine? Y / N All the time? Y / N
With exercise____, With cough____
Pain with Intercourse? Y / N
Problems with Erections? Y / N
Have you had this problem before? Y / N
When?_____

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

List all serious illnesses including hospitalizations:

☐ None _____

_____

_____

_____

Have you ever been diagnosed with:
Circle yes (Y) or no (N)

Y	N	Urinary Tract Infections	Y	N	Cancer Type
Y	N	Prostate Problems	Y	N	Kidney Stones
Y	N	Heart Attack	Y	N	Venereal Disease
Y	N	Heart Disease	Y	N	Heart Murmur
Y	N	Stroke	Y	N	Vascular Disease
Y	N	Blood Clots	Y	N	Diabetes
Y	N	High Blood Pressure	Y	N	Epilepsy/Seizures
Y	N	Asthma	Y	N	Emphysema
Y	N	Pneumonia	Y	N	Ulcers

List all serious illnesses in your immediate family:

☐ None _____

Mother: Living___ Died___ Age___ Died of_____
Father: Living___ Died___ Age___ Died of_____
Occupation (Specify)_____
Marital Status:_____ Years? _____
How many children?_____
Females: Are you pregnant? Y / N How many pregnancies?_____
Vaginal____C-Section____Date of last menstrual period:_____
Do you smoke? Y / N Have you smoked in the past? Y / N
How much?_____ How long?_____
Do you drink alcohol? Y / N
How much? Beer_____ Wine_____ Liquor_____
Coffee Y / N How much?_____
Tea Y / N How much?_____
Soda Y / N How much?_____ What kind?_____

List all surgeries:

_____

_____

Current medications (including over-the-counter and herbal medications):

_____

_____

Acct#_____ **MD**_____

List all drug allergies (along with reactions):

_____

_____

REVIEW OF SYMPTOMS

Are you currently having problems with the following? (Circle yes (Y) or no (N); may place long circle around no answers if appropriate)

Constitution:	Y | N Fever	Gastrointestinal:	Y | N Abdominal pain
	Y | N Chills		Y | N Nausea/vomiting
	Y | N Weight loss		Y | N Indigestion/heartburn
	Y | N Loss of appetite/changes		Y | N Constipation
	Y | N Night Sweats		Y | N Blood in stool
	Y | N Headaches		Y | N Diarrhea
Eyes:	Y | N Blurred vision	Integumentary:	Y | N Skin rash
	Y | N Double vision		Y | N Persistent itch
	Y | N Eye pain		
		Musculoskeletal:	Y | N Joint pain
Allergic/	Y | N Drug Allergies		Y | N Back pain
Immunologic	Y | N Seasonal Allergies		Y | N Neck pain/stiffness
Neurological:	Y | N Tremors	Ear/Nose/	Y | N Earache
	Y | N Seizures	Throat/Mouth	Y | N Sore throat
	Y | N Dizziness spells		Y | N Sinus problems
	Y | N Numbness/tingling		
		Respiratory:	Y | N Shortness of breath
Endocrine:	Y | N Excessive thirst		Y | N Wheezing
	Y | N Fatigue/sluggishness		Y | N Chronic cough
	Y | N Hot/cold feeling		
		Hematologic:	Y | N Easy bruising
Cardiovascular:	Y | N Chest pain		Y | N Bleeding problems
	Y | N High blood pressure		
	Y | N Ankle swelling	Psychologic:	Y | N Depression
			Y | N Anxiety

☐ **ALL OTHER REVIEW OF SYMPTOMS NEGATIVE**

Explain any "Yes" answer in this space:_____

_____

_____

_____

_____

Physician Comments: