

**UROLOGY ASSOCIATES  
PATIENT HISTORY FORM**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

REASON FOR VISIT \_\_\_\_\_

PAST MEDICAL HISTORY \_\_\_\_\_ EXPLANATION  
("Y" - YES OR "N" - NO)

- |   |   |                         |       |
|---|---|-------------------------|-------|
| Y | N | KIDNEY PROBLEMS         | _____ |
| Y | N | BLOOD PRESSURE PROBLEMS | _____ |
| Y | N | DIABETES                | _____ |
| Y | N | HEART ATTACK            | _____ |
| Y | N | IRREGULAR HEART BEAT    | _____ |
| Y | N | LUNG PROBLEMS           | _____ |
| Y | N | HIGH CHOLESTEROL        | _____ |
| Y | N | ULCERS                  | _____ |
| Y | N | SEIZURES                | _____ |
| Y | N | THYROID PROBLEMS        | _____ |
| Y | N | STROKE                  | _____ |
| Y | N | NEUROLOGIC DISEASE      | _____ |
| Y | N | OTHER                   | _____ |

ALLERGIES:  
Y N WHAT KIND \_\_\_\_\_

MEDICATIONS:  
PLEASE LIST: \_\_\_\_\_

<u>PAST SURGERIES:</u>	<u>APPROXIMATE DATE</u>
Y N BLADDER SUSPENSION	_____
Y N CYSTOCELE/RECTOCELE	_____
Y N GALLBLADDER	_____
Y N KIDNEY STONES	_____
Y N VASCULAR SURGERY	_____
Y N HEART BY-PASS	_____
Y N HEART VALVE	_____
Y N APPENDIX	_____
Y N HEMORRHOIDS	_____
Y N TONSILS / ADENOIDS	_____
Y N BREAST BIOPSY	_____
Y N MASTECTOMY	_____
Y N HYSTERECTOMY	_____
Y N NEUROLOGICAL	_____
Y N CAESARIAN SECTION	_____
Y N OTHER (PLEASE LIST)	_____

HOW MANY PREGNANCIES / HOW MANY CHILDREN (AGES): \_\_\_\_\_

SOCIAL HISTORY

Y N DO/HAVE YOU SMOKED (HOW MUCH) ?	_____
Y N DO YOU DRINK ALCOHOL (HOW MUCH) ?	_____
Y N MARRIED?	_____
Y N EMPLOYMENT?	_____
Y N DATE	_____

FAMILY HISTORY

Y N KIDNEY STONES	_____
Y N KIDNEY CANCER	_____
Y N KIDNEY FAILURE	_____
Y N PROSTATE CANCER	_____
Y N BLADDER CANCER	_____
Y N OTHER	_____

DATE BY DOCTOR: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Do you now or have you had any problems related to the following systems?  
(Circle "Y" - Yes or "N" - No)

Constitutional Symptoms

Chills / Fever	Y	N
Weight Loss	Y	N
Tired / Sluggish	Y	N
Other	_____	

Eyes

Vision changes	Y	N
Glaucoma	Y	N
Pain	Y	N
Other	_____	

EAR / NOSE / THROAT / MOUTH

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other	_____	

Psychiatric

Depression	Y	N
Stress	Y	N
Other	_____	

Neurologic

Headache	Y	N
Dizzy	Y	N
Tremors	Y	N
Numbness/Tingling	Y	N
Other	_____	

Endocrine

Excessive Thirst	Y	N
Too Hot / Cold	Y	N
Other	_____	

Gastrointestinal

Abdominal Pain	Y	N
Nausea / Vomiting	Y	N
Indigestion / Heartburn	Y	N
Other	_____	

Cardiovascular

Chest Pain	Y	N
Leg Pain	Y	N
Bleeding Problems	Y	N
Other	_____	

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other	_____	

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Other	_____	