Urology Patient History Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization.

Today's Date_____Date of birth_____Age_____Chart Number_____

Last Name_____First_____M1_____SS#_____

Chief Compliant: (please tell us about your problem including how long it has been present, does it vary, how long does it last, is there anything that affects it, and does it interfere with your normal life.)

_____
_____
_____
_____
_____
_____

History of Present Illness
(Doctors use only)

Location Quality Severity Duration Timing Context

Modifying Factors

Assoc. Signs and Symptoms

Past Medical and Social History

Please list all medical problems and all surgeries with approximate dates.

_____
_____
_____

Please list all medications.

_____
_____
_____

Are you allergic to any medications?_____

Please list any major illnesses in your family. (For example – father has diabetes).

_____
_____
_____
_____

Do you now or have you ever smoked? ☐ Yes ☐ No
If so, how old were you when you started?_____ Quit?_____
How many packs per day?_____

Review of Systems

Do you now or have you had any problems related to the following systems? Check Yes or No.

Please explain any Yes answers in the space provided.

Constitutional Symptoms
- Fever ☐Y ☐N
- Chills ☐Y ☐N
- Headache ☐Y ☐N
- Other _____

Eyes
- Blurred vision ☐Y ☐N
- Double vision ☐Y ☐N
- Pain ☐Y ☐N
- Other _____

Allergic/Immunologic
- Hay Fever ☐Y ☐N
- Drug allergies ☐Y ☐N
- Other _____

Neurological
- Tremors ☐Y ☐N
- Dizzy Spells ☐Y ☐N
- Numbness/tingling ☐Y ☐N
- Other _____

Endocrine
- Excessive thirst ☐Y ☐N
- Too hot/cold ☐Y ☐N
- Tired/sluggish ☐Y ☐N
- Other _____

Gastrointestinal
- Abdominal pain ☐Y ☐N
- Nausea/vomiting ☐Y ☐N
- Indigestion/heartburn ☐Y ☐N
- Other _____

Cardiovascular
- Chest pain ☐Y ☐N
- Varicose veins ☐Y ☐N
- High blood pressure ☐Y ☐N
- Other _____

Integumentary
- Skin rash ☐Y ☐N
- Boils ☐Y ☐N
- Persistent itch ☐Y ☐N
- Other _____

Musculoskeletal
- Joint pain ☐Y ☐N
- Neck pain ☐Y ☐N
- Back pain ☐Y ☐N
- Other _____

Ear/Nose/Throat/Mouth
- Ear infection ☐Y ☐N
- Sort throat ☐Y ☐N
- Sinus problems ☐Y ☐N
- Other _____

Genitourinary
- Urine retention ☐Y ☐N
- Painful urination ☐Y ☐N
- Urinary frequency ☐Y ☐N
- Other _____

Respiratory
- Wheezing ☐Y ☐N
- Frequent Cough ☐Y ☐N
- Shortness of breath ☐Y ☐N
- Other _____

Hematologic/Lymphatic
- Swollen glands ☐Y ☐N
- Blood clotting problem ☐Y ☐N
- Other _____

Psychologic
- Are you generally satisfied with your life? ☐Y ☐N
- Do you feel severely depressed? ☐Y ☐N
- Have you considered suicide? ☐Y ☐N
- Other _____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0-1	1 or 2
2-9	3
10+	4 or 5

Physician _____ Date _____