PATIENT HISTORY FORM

Acct#_____ (office use only)

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 to do so.

Today's Date: _____ Last Physical Exam:_____ Referring Physician:_____

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Age: _____

Chief Complaint: What is the main reason for your visit today: (Describe your problem in detail).

_____

_____

History of Present Illness

Please answer the following questions:

Location of Problem:

_____

_____

_____

On a Scale of 1 – 10, with 10 being the most Severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago

1 month ago

How long does the problem last:

30 minutes 1 hour

It is always there

Is the problem constant or variable?

Does anything help or make the problem worse?

Moving around Standing up

Lying on my side

Is anything else occurring at the same time?

Yes No If yes, please explain.

_____

Past Medical and Social History

Current Health Conditions:

_____ _____ _____

_____ _____ _____

_____ _____ _____

List Prior Surgeries:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications:

_____

Medication Allergies: **General Allergies:**

_____

Mother: Alive ☐ Deceased ☐ **Father: Alive ☐ Deceased ☐** **Adopted: ☐**

Family Medical Problems: (Any Urological Cancer)

_____

Smoke: **Drink Alcohol:** Yes No How much_____

Yes No How much_____

History of Smoking # years _____ packs per day _____ **Year you quit _____**

Review of Systems

Name:_____Date of Birth:_____

Do you now or have you had any chronic/severe problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided.

Constitutional Symptoms			Integumentary		
Fever	Y	N	Skin rash	Y	N
Chills	Y	N	Boils	Y	N
Headache	Y	N	Persistent itch	Y	N
Other	Y	N	Musculoskeletal		
			Joint pain	Y	N
Eyes			Neck pain	Y	N
Blurred vision	Y	N	Back pain	Y	N
Double vision	Y	N	Ear/Nose/Throat/Mouth		
Pain	Y	N	Ear infection	Y	N
Other	Y	N	Sore throat	Y	N
Allergic/Immunologic			Sinus problems	Y	N
Hay fever	Y	N	Genitourinary		
Drug allergies	Y	N	Urine retention	Y	N
Other	Y	N	Elevated PSA	Y	N
Neurological			Urinary frequency	Y	N
Tremors	Y	N	Change in Urine Color	Y	N
Dizzy spells	Y	N	Cloudy Urine	Y	N
Numbness/tingling	Y	N	Decreased Stream	Y	N
Other	Y	N	Painful urination (dysuria)	Y	N
Endocrine			Flank Pain	Y	N
Excessive thirst	Y	N	Back Pain	Y	N
Too hot/cold	Y	N	bed wetting (enuresis)	Y	N
Tired/sluggish	Y	N	Blood in Urine	Y	N
Other	Y	N	Urgency	Y	N
Gastrointestinal			Split Stream	Y	N
Abdominal pain	Y	N	Excessive Urination	Y	N
Nausea/vomiting	Y	N	get up at night to Urinate(nocturia)	Y	N
Indigestion/heartburn	Y	N	Low Urine Output	Y	N
Other	Y	N	Incontinence	Y	N
Cardiovascular			Hesitancy	Y	N
Chest Pain	Y	N	Passing Stones	Y	N
Varicose veins	Y	N	Groin Pain	Y	N
High blood pressure	Y	N	Groin Mass	Y	N
Other	Y	N	Erectile dysfunction	Y	N
Hematologic/Lympatic			Psychological		
Swollen Glands	Y	N	Are you generally satisfied		
Blood clotting problem	Y	N	with your life?	Y	N
Respiratory			Do you feel severely		
Wheezing	Y	N	depressed?	Y	N
Frequent cough	Y	N	Have you considered		
Shortness of breath	Y	N	suicide?	Y	N

_____

_____

Reviewed by:_____ Date:_____ Reviewed by:_____ Date:_____