

PATIENT HISTORY FORM

Today's Date: ___ / ___ / ___

LAST NAME: _____ FIRST NAME: _____ MI _____ DATE OB BIRTH: ___ / ___ / ___

CHIEF COMPLAINT: What is the main reason for your visit to the urologist today? _____

HISTORY OF YOUR PRESENT ILLNESS: Please answer the following questions by circling the appropriate answer or filling in the corresponding blanks.

Location of your problem: Abdomen Back Flank

Bladder Genitals Other _____

Location of your problem: Left Right Central N/A

Does the severity of the problem change from time to time? Yes No

On a Scale of 1 to 10, with 10 being the most sever, circle

The number that best describes the severity of your problem

1 2 3 4 5 6 7 8 9 10

When did your problem first begin?

___ days ago ___ weeks ago ___ months ago

Other _____

Does anything make the problem worse?

Moving around Standing Up Lying on my side

Nothing Other _____

Does anything make the problem better?

Pain medication Nothing Other _____

How long does the problem last?

___minutes ___hours it is always there

Other _____

Is anything else occurring at the same time?

Nausea Vomiting Fever Difficulty Urinating

Painful Urination Other _____

Physician use only: (Comments/Notes)

YOUR CURRENT MEDICAL HISTORY: Current medications: _____

Drug Allergies _____

Chronic Illnesses (please circle) Hypertension Diabetes Reflux (GERD) Asthma COPD Glaucoma Other _____

YOUR PAST MEDICAL HISTORY:

List any urologic surgeries/procedures and the date

List any other major surgeries and the date

FAMILY HISTORY of UROLOGICAL PROBLEMS: Does anyone in your immediate family (brothers, sisters, parents,) have any of the following?

(Please Circle) Bladder Cancer Prostate Cancer Kidney Cancer Kidney Disease Kidney Stones

SOCIAL HISTORY: (please circle) Do you smoke? Yes No how much? _____ Do you drink alcohol? Yes No how much? _____

Review of Systems

Do you currently have any problems related to the following systems? Circle 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
Sore 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
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Physician use only: (Comments/Notes)

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

Physician: _____

Date: ____/____/____