MEDICAL HISTORY

PATIENT NAME: ______________________________ DOB ______________ DATE: ____________

UROLOGY PHYSICIAN NAME: ______________________ REFERRING DOCTOR: ______________________

PROBLEM/CHIEF COMPLAINT: ____

____

Medications: (name and dosage)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

(Medication) Allergies: ____

____

Medical History:

	Yes	No		Yes	No		Yes	No
Abnormal Pap			Diabetes mellitus			Liver disease		
Allergies			Elevated PSA			PVD		
Anemia			Glaucoma			STD		
Asthma			HIV/AIDS			Stroke		
Clotting Disorder			Hormone problems			Thyroid disease		
Colitis/bowel disease			Hypertension			Ulcers		
Colon polyps			Infertility			Urinary tract infection		
COPD			Kidney Disease			Vaginal infections		
Coronary Artery Disease			Kidney Stones					

Surgical history:

	Yes	No		Yes	No		Yes	No
Appendectomy			Kidney Removal			Valve Replacement		
Bladder Surgery			Kidney Transplant			Vasectomy		
C-Section			Lithotripsy					
Cholecystectomy			Ovary removal			Other:		
Colon Surgery			Prostate Surgery					
Cystoscopy			Small intestine surgery					
Hernia repair			Stone Surgery					
Hysterectomy			Testicle removal					
Joint replacement			Tubal Ligation					

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Family History

	Father	Mother	Maunt	Munc	Paunt	Punc	PGM	PGF	MGM	MGF	Other
Anesthesia Problems											
Cancer											
Clotting disorder											
GU problems											
Heart disease											
Hypertension											
Kidney Cancer											
Kidney Failure											
Kidney Stones											
Malignant hyperthermia											
Prostate cancer											
Sickle cell trait											
Lupus											
Sudden death											
Urolithiasis											

Comments/details: ____

____

Social history:

Married/Other:____

Children____How Many?____

Alcohol____ How Much?____

Cigarettes?_____________________________________How Many?___________________(packs per day_______) How Long?___________

Sexually active: ____

Partners: (Male/Female)____

Birth Control:____

Drug use: ____ Yes _____ No

Review of Systems:

Comments:

Constitutional Symptoms	Yes	No
Activity Change		
Appetite Change		
Chills		
Diaphoresis		
Fatigue		
Fever		
Unexpected weight change		

COMMENTS:

HENT	**Yes**	**No**
Facial Swelling		
Neck pain		
Neck Stiffness		
Ear discharge		
Hearing Loss		
Ear Pain		
Tinnitus		
Nose bleeds		
Congestion		
Rhinorrhea		
Postnasal Drip		
Sneezing		
Sinus Pressure		
Dental Problem		
Drooling		
Mouth Sores		
Trouble Swallowing		
Voice Change		

Eyes	**Yes**	**No**
Eye Discharge		
Eye Itching		
Eye Pain		
Eye Redness		
Photophobia		
Visual disturbance		

Respiratory	**Yes**	**No**
Apnea		
Chest tightness		
Choking		
Cough		
Shortness of breath		
Stridor		
Wheezing		

Cardiovascular	**Yes**	**No**
Chest pain		
Leg Swelling		
Palpitations		

COMMENTS:

GI	**Yes**	**No**
Abnormal Distention		
Abnormal Pain		
Anal Bleeding		
Blood in stool		
Constipation		
Diarrhea		
Nausea		
Rectal pain		
Vomiting		

Genitourinary	**Yes**	**No**
Difficulty Urinating		
Dyspareunia		
Dysuria		
Enuresis		
Flank Pain		
Frequency		
Genital Sore		
Hematuria		
Menstrual Problem		
Pelvic Pain		
Urgency		
Urine Decreased		
Vaginal bleeding		
Vaginal Discharge		
Vaginal pain		

Musculoskeletal	**Yes**	**No**
Arthralgias		
Back Pain		
Gait Problem		
Joint Swelling		
Myalgias		

Skin	**Yes**	**No**
Color change		
Pallor		
Rash		
Wound		

Neurological	**Yes**	**No**
Dizziness		
Facial Asymmetry		
Headaches		
Light headedness		
Numbness		
Seizures		
Speech difficult		
Syncope		
Tremors		
Weakness		

Hematologic	**Yes**	**No**
Adenopathy		
Bruises/bleeds easily		

Psychiatric	**Yes**	**No**
Agitation		
Behavior Problem		
Confusion		
Decreased Concentration		
Dysphoric mood		
Hallucinations		
Hyperactive		
Nervous/Anxious		
Self Injury		
Sleep disturbance		
Suicidal ideas		