

PATIENT HISTORY FORM

TODAY'S DATE ____/____/____

DATE OF BIRTH ____/____/____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

History of Present Illness

Reason for this visit. _____

Duration of above complaint. Please indicate number. ____ week(s) ____ month(s) ____ year(s)

Have you been treated for this condition in the past? Yes No If yes, please explain.

Frequency of urination Daytime ____ Nighttime ____ Strength of stream Normal ____ Decreased ____ Poor ____

Are you currently experiencing any of the following symptoms? Please circle Yes or No

| | Comments | | | Comments | |
|--------------------------|----------|---|---|----------|---|
| Blood in urine | Y | N | Leakage of urine | Y | N |
| Urinary Infections | Y | N | Interruption of urinary stream | Y | N |
| Kidney or bladder stones | Y | N | Split stream | Y | N |
| Urgent urination | Y | N | Burning or discomfort with urination | Y | N |
| Dribbling after voiding | Y | N | Hesitancy in initiating stream | Y | N |
| Recent X-Rays | Y | N | If yes, what type of x-rays were performed and where? | | |

Physician use only:

Past Medical History and Social History

List any personal serious illnesses or surgeries you have had and when they occurred in chronological order with approximate dates.

List all serious illnesses in your immediate family. (Example: diabetes, cancer, heart disease, elevated cholesterol, hypertension. etc.)

Are you currently taking any prescription or non-prescription medications? (Example: aspirin; ibuprofen; hormone replacements; dietary, herbal, or vitamin supplements) Yes No If yes, list all.

Do you have any allergies to medications, Latex, iodine contrast, or adhesives? Yes No If yes, list all.

Have you ever had a blood transfusion? Yes No If yes, when? _____

Do you currently smoke? Yes No If yes, how many packs per day? _____ For how many years? _____

If you have a prior history of smoking: When did you stop? _____ How many packs per day? _____ For how many years? _____

Do you currently drink alcoholic beverages? Yes No

If yes, how much and how often? _____ For how many years? _____

If you have a prior history of drinking, when did you stop? _____

Physician use only:

Review of Systems

Do you now or have you ever had any of the following problems? Circle Yes or No.

Constitutional Symptoms

Fever Yes No
 Chills Yes No
 Other _____

Eyes

Blurred vision Yes No
 Double vision Yes No
 Pain Yes No
 Other _____

Ears/Nose/Throat/Mouth

Ear infection Yes No
 Hearing Aid Yes No
 Sore throat Yes No
 Hoarseness Yes No
 Change in swallowing Yes No
 Sinus problems Yes No
 Other _____

Cardiovascular

Chest pain Yes No
 Heart palpitations Yes No
 History of heart attack Yes No
 High blood pressure Yes No
 Varicose veins Yes No
 Other _____

Respiratory

Asthma Yes No
 Wheezing Yes No
 Chronic cough Yes No
 Shortness of breath Yes No
 Other _____

Hematologic/Lymphatic

Blood clotting problem Yes No
 Easy bruising Yes No
 Swollen glands Yes No
 Other _____

Endocrine

Are you a diabetic Yes No
 Excessive thirst Yes No
 Too hot / cold Yes No
 Tired / sluggish Yes No
 Hypothyroid / Hyperthyroid Yes No
 Other _____

Musculoskeletal

Joint pain Yes No
 Neck pain Yes No
 Back pain Yes No
 Other _____

Integumentary

History of jaundice Yes No
 Skin rash Yes No
 Boils Yes No
 Persistent itch Yes No
 Other _____

Gastrointestinal

Abdominal pain Yes No
 Indigestion / heartburn Yes No
 Nausea / vomiting Yes No
 Diarrhea Yes No
 Constipation Yes No
 Blood in stool / black stool Yes No
 History of ulcer Yes No
 Other _____

Gynecologic

Are you presently pregnant Yes No
 Last menstrual date _____
 Menopause – If yes, age _____
 Difficulty having intercourse Yes No

Neurologic

Headache Yes No
 Tremors Yes No
 Dizzy spells Yes No
 History of fainting / seizures Yes No
 History of numbness / weakness Yes No
 Other _____

Psychologic

History of depression Yes No
 Other _____

Infections/Sexually Transmitted Diseases

Hepatitis Yes No
 HIV / AIDS Yes No
 Chlamydia Yes No
 Genital Herpes Yes No
 Genital Venereal Warts Yes No
 Syphilis Yes No
 Other _____

Physician use only:

Physician _____

Date ____ / ____ / ____