Urology Surgeons, P.C.

Medical History Form

Name_____ Date of Birth_____

The following information will assist us in providing you the most excellent care. This information is a confidential record. ***Please fill out all three pages of these forms completely.***

History of Present illness: Please answer the following questions

- What is the main reason for your visit? (Describe your problem in detail) _____

  _____

  _____
- Location of the problem: □ Abdomen □ Back □ Leg □ Pelvis □ Other_____
- 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 □ Other _____
- Does anything help or make the problem worse? □ Moving around □ Standing up □ Lying on side □ Other _____

  _____
- How long does the problem last? □ 30 minutes □ 1 hour □ Is it always there □ Other _____
- Is anything else occurring at this time: □ Yes □ No If yes, please explain: □ Nausea □ Headaches □ Fever Other _____
- Is the problem constant or variable □ Dull, then sharp □ Very sharp, then leaves □ Always there □ Other _____

  _____
- Does the problem interfere with your normal functions? □ Yes □ No If yes, please explain. _____

  _____

Height_____ **Weight**_____ **Gender**_____

Have you ever had the following (circle all that apply)

Anemia
Anxiety/Depression
Arthritis
Asthma
Blood clotting disorder
Cataracts
Chronic Bronchitis / COPD
Cirrhosis of Liver
Colitis
Congestive Heart Failure
Diabetes Type
Diverticulitis
DVT
Elevated Cholesterol
Emphysema
Enlarged Prostate
Epilepsy
GERD/Heartburn
Glaucoma
Gout
Heart Attack
Heart Disease
Hepatitis B or C
High Blood Pressure
Intestinal Bleeding
HIV/Immunosuppressed
Joint Replacement
Kidney Stone: when?
Kidney Disease
Kidney Infection
Liver Disease
Migraines
Pacemaker
Parkinson's Disease
Prostate Problems
Sleep Apnea/CPAP
Stroke
Thyroid Problems
Vascular Heart Disease
Cancer—NO
Cancer—YES:
What kind? _____
Treatment? _____

Other medical problems:
_____
_____
_____

Use of Blood Thinners?
Aspirin Yes / No
Plavix Yes / No
Coumadin/Warfarin Yes / No
Pradaxa Yes / No

Any of the sections that do not apply please mark with N/A

List all surgeries and procedures and approximate date

Surgery/Procedure	Year Performed	Surgery/Procedure	Year Performed

List all prescription and over-the-counter medications and supplements you take regularly – attach separate sheet if needed

Medication	Dose	Frequency (how often)	Prescribing Physician (or over the counter)

List all medication allergies and the reaction you had when you took them

Allergic To:	Reaction	Allergic To:	Reaction

Family History *Are You Adopted? NO YES*

Has any blood relative had any of the following? *Indicate "M" for mother's side, "P" for father's side or if other family member*

Problem	Family Member	Age Onset	Problem	Family Member	Age Onset
Blood Disorder			Kidney Stones		
Cancer-what kind			Heart Disease		
Prostate Cancer			Blood Clotting disorder		
Testicular Cancer			Hypertension		
Bladder Cancer			Kidney Disease		
Kidney Cancer			Other		

Women Only

Menopause YES, since age _____
NO: First day of most recent menstrual period: _____
How many pregnancies have you had? _____
Are you currently pregnant? NO / YES

Vaginal Delivery? #_____ C-section? #_____
Current birth control? _____
Any hormone replacement? _____
Are you sexually active? YES / NO

Men Only

History of erectile dysfunction? NO / YES, how long? _____ days / months / years
Any previous treatments: _____
Are you sexually active? YES / NO

Social History

What is your occupation? _____
Marital status: Single Engaged Married Divorced Widowed
Do you use tobacco products? Never / Former- when quit? _____ / Yes—how much per day/week? _____
Do you drink alcohol? Never / Former- when quit? _____ / Yes—how much per day/week? _____
Do you use illegal drugs? Never / Former- when quit? _____ / Yes—how much per day/week? _____
Do you drink caffeine? Never / Former- when quit? _____ / Yes—how much per day? _____
How much exercise do you get? Sedentary 1-2 times/mo 1-2 times/wk 3-4 times/wk nearly every day daily
Have you ever been exposed to harmful chemicals at work or elsewhere? NO YES (explain) _____

Please circle any symptoms you are *currently* having, or have had *recently*:

CONSTITUTIONAL
Fever
Chills
Headache
Weight change past 3 months
Gain: How much
Loss: How much

EYES
Blurred vision
Double vision
Eye pain

EAR/NOSE/THROAT
Ear infection
Sore throat
Sinus Problem

CARDIOVASCULAR
Chest pain
Irregular heart beat

RESPIRATORY
Wheezing
Frequent cough
Shortness of breath

GASTROINTESTINAL
Abdominal pain
Nausea/vomiting
Indigestion/heartburn
Constipation
Diarrhea

GENITOURINARY
Nighttime Frequency
Daytime Frequency
Burning/painful urination
Delayed/weak stream
Brown, black urine
Bloody urine
Involuntary loss of urine/Dribbling

SKIN
Rash
Boils
Persistent itching

NEUROLOGIC
Tremors
Dizzy spells
Numbness/tingling

MUSCULOSKELETAL
Joint pain
Neck pain
Back pain

ENDOCRINE
Excessive thirst
Heat intolerance
Cold intolerance
Decreased libido

PSYCHOLOGIC
Generally dissatisfied with life
Depression
Considered suicide

HEME-LYMPH
Easy bleeding
Easy bruising
Swollen glands

ALLERGY/IMMUNE
Seasonal allergies