UROLOGY PATIENT HEALTH HISTORY

Name: _____ Date of Birth: _____ Age: _____Todays Date: _____

Occupation: _____ Pharmacy: _____

Reason for visit: _____ **(Check here for <u>Private matter</u> ☐)** Height: ___Weight: ___

HEALTH HISTORY

REVIEW OF SYSTEMS

1. Are you currently experiencing any of the following symptoms? (Please choose NO or YES for every item)

A) CONSTITUTIONAL
Chills…… □ NO □ YES
Fever…… □ NO □ YES
Weight Loss…… □ NO □ YES

B) **HEAD/EYES/EARS/NOSE/THROAT**
Blurred vision…… □ NO □ YES
Ear infection…….. □ NO □ YES
Hearing Loss …… □ NO □ YES
Sore throat…….. □ NO □ YES
Other: _____

C) RESPIRATORY
Frequent Cough…… □ NO □ YES
Wheezing.....…… □ NO □ YES
Shortness of breath……. □ NO □ YES
Other: _____

D) CARDIOVASCULAR
Chest Pain……..…… □ NO □ YES
Heart Murmur…….…….. □ NO □ YES
Palpitations …… □ NO □ YES
Varicose Veins…….. □ NO □ YES
Other: _____

E) **GASTROINTESTINAL**
Abdominal pain …… □ NO □ YES
Blood in Stool…… □ NO □ YES
Constipation……. □ NO □ YES
Diarrhea…… □ NO □ YES
Indigestion/heartburn ……. □ NO □ YES
Loss of Appetite…….. □ NO □ YES
Nausea……. □ NO □ YES
Vomiting…….. □ NO □ YES
Other: _____

F) GENITOURINARY
Painful urination..…… □ NO □ YES
Erectile Dysfunction…… □ NO □ YES
Blood in urine …….. □ NO □ YES
Urinary retention …… □ NO □ YES
Frequency …….. □ NO □ YES
Incontinence ……. □ NO □ YES

GENITOURINARY (cont.)
Urgency..…….. □ NO □ YES
Urinary infection …….. □ NO □ YES
Kidney stones…….. □ NO □ YES
Prostatitis…….. □ NO □ YES
Urinate during night……. □ NO □ YES
# of times _____
Penile discharge…….. □ NO □ YES
Sexual dysfunction…….. □ NO □ YES
Other _____

G) ENDOCRINE
Excess thirst……. □ NO □ YES
Tired/sluggish …….. □ NO □ YES

H) NEUROLOGICAL
Headache…….. □ NO □ YES
Memory loss……. □ NO □ YES
Numbness …… □ NO □ YES
Other: _____

I) PSYCHOLOGIC
Depression..…… □ NO □ YES
Anxiety ……. □ NO □ YES
Other: _____

J) INTEGUMENTARY
Skin rash…….. □ NO □ YES

K) MUSCULOSKELETAL
Back pain …… □ NO □ YES
Joint pain …… □ NO □ YES
Other: _____

L) HEMATOLOGIC/LYMPHATIC
Blood clots…….. □ NO □ YES
Other: _____

M) IMMUNOLOGIC
Hay fever …….. □ NO □ YES
Gout..…….. □ NO □ YES
Other: _____

CANCER HISTORY

2. Have you ever been diagnosed with any type of cancer? □ NO □ YES *If you answered "YES"; please list the type(s) of cancer:*

Cancer: _____ Year: _____

Cancer: _____ Year: _____

Cancer: _____ Year: _____

Name: _____ Date of Birth: _____ Date: _____

PAST MEDICAL HISTORY

3. Have you ever had surgery before?

Hernia Repair……	□ NO	□ YES	Vasectomy……	□ NO	□ YES
Gallbladder Removal……	□ NO	□ YES	TURP……	□ NO	□ YES
Appendectomy……	□ NO	□ YES	Prostatectomy (prostate removal)…..	□ NO	□ YES
Cardiac Stents……	□ NO	□ YES	Nephrectomy (kidney removal)……..	□ NO	□ YES
Open Heart Surgery……..	□ NO	□ YES	Bladder Surgery……	□ NO	□ YES
Type_____			Type_____		
Hysterectomy……	□ NO	□ YES	Prostate Biopsy……	□ NO	□ YES
Tubal Ligation……	□ NO	□ YES	Colonoscopy……...	□ NO	□ YES
Back Surgery……	□ NO	□ YES	Upper Endoscopy……...	□ NO	□ YES

OTHER:

Operation: _____ Year: _____

Operation: _____ Year: _____

ANY COMPLICATIONS? (e.g., excessive bleeding, blood clots) _____

4. Have you ever had any of the following medical conditions?

High blood pressure……	□ NO	□ YES	Sickle cell disease…….	□ NO	□ YES
High cholesterol……..	□ NO	□ YES	Diabetes……..	□ NO	□ YES
Atrial Fibrillation……..	□ NO	□ YES	Thyroid disease……..	□ NO	□ YES
Heart attack……	□ NO	□ YES	Urinary infection……	□ NO	□ YES
Heart failure……	□ NO	□ YES	Kidney stones……	□ NO	□ YES
Coronary artery disease……	□ NO	□ YES	Prostatitis……	□ NO	□ YES
Pacemaker/Defibrillator…….	□ NO	□ YES	Sexually transmitted disease……	□ NO	□ YES
Asthma……	□ NO	□ YES	Type_____		
COPD/Emphysema……	□ NO	□ YES	Stroke……..	□ NO	□ YES
Sleep Apnea……	□ NO	□ YES	Migraines……	□ NO	□ YES
Do you use a CPAP or BIPAP?	□ NO	□ YES	Depression……	□ NO	□ YES
Reflux/Heartburn……	□ NO	□ YES	Anxiety/Panic attacks……	□ NO	□ YES
Hepatitis……..	□ NO	□ YES	Drug/alcohol abuse……	□ NO	□ YES
Colitis/Enteritis……..	□ NO	□ YES	Gout……	□ NO	□ YES
Bleeding disorder……..	□ NO	□ YES	HIV/AIDS…….	□ NO	□ YES

OTHER:

_____

_____

_____

MEDICATION HISTORY

5. Please list all **prescribed** medications you currently use and the dosage and frequency of each.

Current medications	Dosage/Frequency	Current medications	Dosage/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Please list all **over-the-counter** medications you currently use and the dosage and frequency of each.

Medication/Supplement/Vitamin/Herb	Dosage/Frequency
_____	_____
_____	_____
_____	_____
_____	_____

Ibuprofen □ NO □ YES If YES, what dosage? _____

Aspirin □ NO □ YES If YES, what dosage? _____

Name: _____ Date of Birth: _____ Date: _____

FAMILY/PERSONAL HISTORY

7. Have any of your immediate family had cancer? □ NO □ YES *If you answered "YES"; please list the type(s)of cancer below.*

   Type: _____ Family Member: _____

   Type: _____ Family Member: _____

8. Current marital status: □ Never married □ Married □ Separated □ Divorced □ Living with partner □ Widowed

9. Children? □ NO □ YES If "YES", how many Sons? _____ Daughters? _____

SOCIAL HISTORY

10. Alcohol Use: □ None □ Rarely (social) □ Often □ Quit, If so, when? _____
    What type of alcohol do you drink? □ Beer □ Wine □ Hard liquor

11. Caffeine Use: □ Daily Amount and Type _____
    □ Sometimes Amount and Type _____
    □ Never

12. Tobacco Use:

    Present:
    Currently smokes cigarettes regularly (at least one a day)? □ NO □ YES
    Currently on average, how many cigarettes do you smoke per day? (one pack = 20) # of cigarettes _____

    Past:
    In the past, have you ever smoked cigarettes regularly (at least 100 cigarettes)? □ NO □ YES
    How many years have you smoked cigarettes regularly (at least once a day)? _____ years
    In the past, on average, how many cigarettes did you smoke per day? (one pack = 20) # of cigarettes _____
    If you have quit smoking, what year did you quit? _____
    Do you currently smoke cigars/pipe/smokeless tobacco? □ NO □ YES

13. Drug Use:

    Present: □ NO □ YES *If you answered "YES", what type(s)?* _____

    Past: □ NO □ YES *If you answered "YES", what type(s)?* _____

ALLERGIES

14. Allergies: List ALL allergies, including **medications, foods, latex, or IVP dyes**

    _____ _____

    _____ _____

    _____ _____

    □ Check if no known drug allergies

Patient Signature: _____ Date: _____

Or Designee Signature: _____ Date: _____

Reviewed by: _____ Date:_____