PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your consent to do so.

Date: _____ / _____ / _____

Last Name ____________________________ First name _________________________ Middle Name _____________________

Social Security No. _____________________________ Date of Birth _____ / _____ / _____

Primary Care Provider: ___________________________________ Pharmacy: ____

HISTORY OF PRESENT ILLNESS

Chief complaint: What is the main reason for your visit? Please describe

____

____

How long have you had symptoms? 1 week 1 month 1 year Other: ________________________	On a scale of 1-10, with 10 being the most severe, how would you rate your pain or problem? 1 2 3 4 5 6 7 8 9 10	How long does the pain or problem last? 30 mins 1 hour Always there Other: _______________________
Does anything improve the pain? If yes, what? ___________________________________ Does anything make the pain worse? If yes, what? ___________________________________	Is the problem or pain constant or variable?	Does the pain or problem interfere with normal functions?

MEDICAL HISTORY

Personal Medical History: Check any past or present medical conditions or diagnosis

Non-Urological		**Urological**	
☐ Anxiety	☐ Dementia	☐ Urinary Tract Infection	☐ Pyelonephritis
☐ Asthma	☐ Glaucoma	☐ Incontinence	☐ Interstitial Cystitis (IC)
☐ Blood Clot	☐ High Blood Pressure	☐ Urinary retention	☐ Urethral stricture
☐ Cancer	☐ High Cholesterol	☐ Kidney stones	☐ Benign prostatic hypertrophy (BPH)
☐ Chronic pain	☐ Heart disease	☐ Prostate cancer	☐ Bladder cancer
☐ COPD/ Emphysema	☐ Migraine	☐ Renal cancer	☐ Testicular cancer
☐ Diabetes	☐ Stroke	☐ Kidney disease	☐ Bladder prolapse
☐ Depression	☐ Thyroid disease	☐ Low testosterone	☐ Erectile Dysfunction

Please list prior surgeries and date:

____

For Males:

Have you had previous annual prostate cancer screening with a PSA? If yes, where was it completed? _______________________

Has your PSA ever been abnormal? Yes No

Have you had a previous prostate biopsy? Yes No

For Females:

When was your last pap smear and pelvic exam? _____ / _____ / _____

When was date of your last menstrual period? If postmenopausal, please write N/A. _____ / _____ / _____

FAMILY HISTORY & SOCIAL HISTORY

Family History: Please list immediate family history (example: diabetes, cancer, heart disease)

____

____

Social History:

Do you use tobacco products? Yes ______ Former ______ No ________ If yes, how much? ________________

Do you drink alcohol? Yes ______Former ______ No ________ If yes, how much? ________________

Do you drink caffeine (coffee, tea, soda)? Yes ______ No ________ If yes, how much? ________________________________

Do you use illicit drugs? Yes ______ No ________ If yes, which ones? _______________________

Are you sexually active? Yes ______No ________

REVIEW OF SYSTEMS

Do you have any of the following symptoms currently? Please **circle** yes or no.

Constitutional

Fever Yes / No
Chills Yes / No
Recent Weight loss Yes / No

Head/ Neck/ ENT

Headache Yes / No
Neck pain Yes / No
Neck stiffness Yes / No
Ear infection Yes / No
Sore throat Yes / No
Sinus problems Yes / No

Eyes

Blurred vision Yes / No
Double vision Yes / No

Cardiovascular

Chest pain Yes / No
High blood pressure Yes / No
Heart palpitations Yes / No

Pulmonary

Cough Yes / No
Shortness of breath Yes / No
Wheezing Yes / No

Gastrointestinal

Heartburn Yes / No
Nausea Yes / No
Vomiting Yes / No
Abdominal pain Yes / No
Diarrhea Yes / No
Constipation Yes / No

Genitourinary

Painful urination Yes / No
Frequency Yes / No
Urgency Yes / No
Blood in urine Yes / No
Incontinence Yes / No
Diminished urine flow Yes / No
Urinary retention Yes / No

Endocrine

Excessive thirst Yes / No
Tired/ sluggish Yes / No
Too hot/ too cold Yes / No
Feeling weak Yes / No

Musculoskeletal

Localized joint pain Yes / No
Chronic back pain Yes / No

Neurological

Tremors Yes / No
Dizziness Yes / No
Sensory disturbances Yes / No

Psychological

Anxiety Yes / No
Depression Yes / No

Skin

Skin changes Yes / No
Skin rash Yes / No
Persistent itching Yes / No

	Straining to urinate Yes / No	

Patient Name: ______________________________ DOB: _____ / _____ / _____

MEDICATION LIST

Please list all of the prescription medications, over the counter medication, and supplements that you are currently taking.

Medication Name	Dosage	How many times a day it is taken

Do you have allergies? Please list allergy and reaction ____