

Southwest Urologic Specialists, PC

PATIENT HISTORY FORM

DATE: \_\_\_\_\_

CONFIDENTIAL

OFFICE USE ONLY: ANNUAL UPDATE: \_\_\_\_\_

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.

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ NICKNAME \_\_\_\_\_

DOB: \_\_\_\_\_ Reason for visit? \_\_\_\_\_

Gender M F (please circle)

Medical History

List your Medical Conditions (i.e. Cancer, Thyroid, ASHD, Diabetes, Hypertension, etc...)

Allergies (circle) none

Grid for listing medical conditions and allergies with year and description fields.

History of Infection

Have you ever had: (circle) Rheumatic Fever TB Valley Fever Immune Disorder None

List your surgical procedures (i.e. Tonsillectomy, appendectomy, hysterectomy, hernia, etc...)

Grid for listing surgical procedures with year and description fields.

Current prescription medicines

Current prescription medicines

Two tables for listing current prescription medicines with columns for drug name, dose, tablets, frequency, and start date.

OTC medicines. (Aspirin, Tylenol, Ibuprofen, Aleve, vitamins and herbals.)

Blank line for listing OTC medicines.

Family History

Form for family history including fields for Living/Deceased status, Illness, Cause of Death/Age, Names, and DOB for family members.

Family History of:	Yes	No	Family Member	Yes	No	Family Member
1. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Social History

Are you adopted?  Yes  No

Married?  Yes  No    Single?  Yes  No    Divorced?  Yes  No    Widow?  Yes  No

Smoke?  Yes  No    If yes, how much? \_\_\_\_\_ # of packs/day    \_\_\_\_\_ # of years    When did you stop smoking? \_\_\_\_\_

Alcohol?  Yes  No    If yes, how much? \_\_\_\_\_

Coffee – how much \_\_\_\_\_     Tea – how much \_\_\_\_\_     Soda – how much \_\_\_\_\_

Have you ever used recreational drugs? (i.e. marijuana, cocaine) If yes, what/when \_\_\_\_\_

**Work History:** Present Occupation: \_\_\_\_\_ Present Employer: \_\_\_\_\_

Retired?  Yes  No    Past Occupation: \_\_\_\_\_ Past Employer: \_\_\_\_\_

### Review of Systems

Do you now or have you had any problems related to the following systems? "Y" or "N" must be circled or answer will be assumed 'NO'

Circle Yes or No.

<b>Constitutional Symptoms</b>			<b>(Comments)</b>	<b>Genitourinary</b>			<b>(Comments)</b>
Weight loss	Y	N	(if yes, how many lbs) _____	Change in stream	Y	N	
Weight gain	Y	N	(if yes, how many lbs) _____	Nocturia (getting up at night)	Y	N	
Chills	Y	N		Urinary frequency > 8 times/day	Y	N	
Fever	Y			Burning with urination	Y	N	
Itching	Y	N		Blood in urine	Y	N	
Night Sweats		N		Trouble starting urine flow	Y	N	
		N		Dribbling at end of urine flow	Y	N	
Other		N		Urinary leakage	Y	N	
				Other			
<b>Eyes</b>				<b>Musculoskeletal</b>			
Glaucoma	Y	N		Muscle weakness	Y	N	
Cataracts	Y	N		Joint pain (swelling)	Y	N	
Wear glasses	Y	N		Sciatica	Y	N	
Blurred Vision	Y	N		Muscle pains	Y	N	
Pain in your eyes	Y	N		Muscle cramps	Y	N	
				Stiffness	Y	N	
Other				Other			
<b>Cardiovascular</b>				<b>Neurological</b>			
Chest pain	Y	N		Tremors	Y	N	
Tightness/heaviness in chest	Y	N		Dizzy spells	Y	N	
Irregular heartbeat	Y	N		Numbness/tingling	Y	N	
Swelling in ankles	Y	N		Stroke	Y	N	
High Blood Pressure	Y	N		Seizures	Y	N	
Shortness of breath	Y	N		Insomnia	Y	N	
Heart enlarged	Y	N					
Low blood pressure	Y	N		<b>ENT</b>			
Feel palpitations	Y	N		Pain in ears	Y	N	
Heart pound fast	Y	N		Discharge from ears	Y	N	
Feel skipped beats	Y	N		Motion sickness	Y	N	
Do you have a murmur	Y	N		Difficulty hearing	Y	N	
				Trouble with teeth	Y	N	
				Trouble with gums	Y	N	
				Nose bleeds	Y	N	

<b>Men Only</b>			
Pain or swelling of testicles	Y N		
Discharge from penis	Y N		
Blood in Semen	Y N		
<b>Psychologic</b>		<b>Respiratory</b>	
Do you feel depressed?	Y N	Wheezing	Y N
Do you feel anxious?	Y N	Frequent cough	Y N
Seeing a psychiatrist	Y N	Shortness of breath	Y N
Any psychiatric diagnosis	Y N	Are you on oxygen	Y N
Other		Other	
<b>Endocrine</b>		<b>Gastrointestinal</b>	
Excessive thirst	Y N	Abdominal pain	Y N
Too hot/cold	Y N	Nausea/vomiting	Y N
Other		Indigestion/heartburn	Y N
		Constipation	Y N
		Diarrhea	Y N
<b>Hematologic/Lymphatic</b>		<b>Sexual History</b>	
Swollen glands	Y N	Change in sex drive?	Y N
Blood clotting problem	Y N	Sexual performance satisfactory?	Y N
Bruising	Y N		
Other			

AUA Symptom Score: Circle one number on each line							
Questions to be answered	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Over the past month, how often have you had to urinate less than 2 hours after you finished urinating?	0	1	2	3	4	5	
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5	
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. On a nightly basis, how many times do you typically get up to urinate?	0	1	2	3	4	5	
<b>Quality of Life Due to Urinary Symptoms</b>	<i>Delighted</i>	<i>Pleased</i>	<i>Mostly Satisfied</i>	<i>Mixed</i>	<i>Mostly Dissatisfied</i>	<i>Unhappy</i>	<i>Terrible</i>
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Sum the seven circled numbers (AUA Symptom Score): \_\_\_\_\_ Scoring: Mild: 0 – 7 Moderate: 8 to 19 Severe: 20 – 35

I hereby acknowledge the above information is accurate and true. **Patient signature** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_