Southwest Urologic Specialists, PC

PATIENT HISTORY FORM

CONFIDENTIAL: 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.

Date _____

Last Name _____ First Name _____MI____

Nickname _____ DOB_____ Gender _____

Reason for Visit _____

Medical History

Allergies NO if yes, _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Medical Conditions (for example- Colon Cancer, Hypertension, Diabetes, etc.)

_____ Year_____ _____ Year_____

_____ Year_____ _____ Year_____

_____ Year_____ _____ Year_____

_____ Year_____ _____ Year_____

_____ Year_____ _____ Year_____

Defibrillator Yes No **Pacemaker** Yes No

Infections

Have you ever had? : Rheumatic Fever, Tuberculosis, HIV, Valley Fever, MRSA, Vancomycin Resistant Enterococcus

Surgeries

_____ Year_____ _____ Year_____

_____ Year_____ _____ Year_____

_____ Year_____ _____ Year_____

_____ Year_____ _____ Year_____

Name of Drug	Dose (mg)	# Tablets	# times per day

Over the Counter Medication (Aspirin, Tylenol, vitamins, fish oil, etc.)

_____ _____ _____

_____ _____ _____

Social History

Married? □ Yes □ No Single? □ Yes □ No Divorced? □ Yes □ No Widowed? □ Yes □ No

Non Smoker □ Current Smoker □ cigarette/cigar/pipe/chew Former Smoker □

How many? _____ day When? _____ until _____

Have you used recreational drugs in the last 12 months? (Marijuana, Cocaine, etc.)? _____ When? _____

Alcohol Use □ Yes □ No If yes, # drinks per week _____ Caffeine □ Yes □ No If yes, # drinks per day _____

Employment: □ Employed □ Retired □ Unemployed

Present Occupation _____ Present Employer _____

Past Occupation _____ Past Employer _____

Family History

Relative	Living	Deceased	Major Illnesses	Cause of Death	Age
Father					
Mother					
Sister(s)	#	#			
Brother(s)	#	#			
Children	#	#			

Is there any history in your family of

□ Heart Disease Relation _____
□ Kidney Disease Relation _____
□ Kidney Stones Relation _____
□ Prostate Cancer Relation _____
□ Diabetes Relation _____
□ GI problems Relation _____
□ Bleeding Disorder Relation _____
□ Other Relation _____

Review of Systems

Do you now or have you had any problems related to the following systems? "Y" or "N" must be circled or "N" will be assumed.

Constitutional				**Musculoskeletal**			
Weight Loss	Y	N	lbs _____	Muscle Weakness	Y	N	
Weight Gain	Y	N	lbs _____	Joint Pain/Swelling	Y	N	
Chills	Y	N		Sciatica	Y	N	
Fever	Y	N		Muscle Pain	Y	N	
Itching	Y	N		Muscle Cramps	Y	N	
Night Sweats	Y	N		Stiffness	Y	N	
Other	Y	N	_____	Other	Y	N	_____

Eyes				**Gastrointestinal**			
Glaucoma	Y	N		Abdominal Pain	Y	N	
Cataracts	Y	N		Nausea/Vomiting	Y	N	
Glasses/Contacts	Y	N		Indigestion/Heartburn	Y	N	
Blurred Vision	Y	N		Constipation	Y	N	
Eye Pain	Y	N		Diarrhea	Y	N	
Other	Y	N	_____	Other	Y	N	_____

Neurological				**Psychological**			
Tremors	Y	N		Depression	Y	N	

Dizziness	Y	N	
Numbness/Tingling	Y	N	
Stroke	Y	N	
Seizures	Y	N	
Insomnia	Y	N	
Other	Y	N	_____

Endocrine

Excessive Thirst	Y	N	
Too Hot / Cold	Y	N	
Other	Y	N	_____

Cardiovascular

Chest Pain	Y	N	
Tightness in Chest	Y	N	
Irregular Heartbeat	Y	N	
Ankle Swelling	Y	N	
High Blood Pressure	Y	N	
Shortness of Breath	Y	N	
Heart Enlarged	Y	N	
Low Blood Pressure	Y	N	
Heart Palpitations	Y	N	
Fast Heart Rate	Y	N	
Skipped Heart Beat	Y	N	
Heart Murmur	Y	N	
Defibrillator or Pacemaker	Y	N	

Genitourinary

Change in Stream	Y	N	
Urinating at Night	Y	N	
Anxiety	Y	N	
Seeing a Psychiatrist	Y	N	
Psychiatric Diagnosis	Y	N	_____
Other	Y	N	_____

Respiratory

Wheezing	Y	N	
Frequent Cough	Y	N	
Shortness of Breath	Y	N	
On Oxygen	Y	N	
Other	Y	N	_____

Ear/Nose/Throat

Pain in Ears	Y	N	
Discharge from Ears	Y	N	
Motion Sickness	Y	N	
Difficulty Hearing	Y	N	
Trouble with Teeth	Y	N	
Trouble with Gums	Y	N	
Nose Bleeds	Y	N	

Hematologic/Lymphatic

Swollen Glands	Y	N	
Blood Clotting Problem	Y	N	
Bruising	Y	N	
Other	Y	N	_____

Sexual History

Change in Sex Drive	Y	N	

Frequency (>8 times/ day)	Y	N	Sexual Performance Satisfactory	Y	N
Burning with Urination	Y	N			
Blood in Urine	Y	N	**Men Only**		
Trouble Starting Flow	Y	N	Pain in Testicles	Y	N
Dribbling after Urination	Y	N	Swelling of Testicles	Y	N
Urinary Leakage	Y	N	Blood in Semen	Y	N
Other	Y	N _____	Discharge from Penis	Y	N

Men Only: Circle the Number	Not at all	Almost Never	Less than half the time	About half the time	More than half the time	Almost always
Over the past month, how often have you had a sensation of not completely emptying your bladder after urinating?	0	1	2	3	4	5
Over the past month, how often have you had to urinate less than two hours after you finished urinating?	0	1	2	3	4	5
Over the past month, how often have you stopped and started again several times when urinating?	0	1	2	3	4	5
Over the past month, how often have you found it difficult to postpone urinating?	0	1	2	3	4	5
Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
On a nightly basis, how many times do you typically wake up to urinate?	0	1	2	3	4	5

Total _____

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
Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible

I hereby acknowledge the above information is accurate and true.

Patient Signature _____ **Date**_____