MIDLANTIC UROLOGY
PATIENT INFORMATION AND HISTORY

HISTORY OF PRESENT ILLNESS

PATIENT NAME:_____ **DATE OF BIRTH:**_____

REASON FOR VISIT:_____

When did you first notice the problem? ☐ **2 days ago** ☐ **2 weeks ago** ☐ **Other**_____

Are your symptoms getting worse? _____

Is the problem ☐ **constant or variable** ☐ **dull then sharp** ☐ **very sharp then leaves** ☐ **always**

Does the problem interfere with your normal activities? ☐ **Yes** ☐ **No (If yes, explain)**_____

_____

Is there anything else occurring at the same time? ☐ **Yes** ☐ **No (If yes, explain)** _____

_____

☐ **Nausea** ☐ **Rash** ☐ **Headache** ☐ **Fever** ☐ **Other** _____

Have you had this problem before? ☐ **Yes** ☐ **No** ☐ **I don't know**

Have you had prior urological evaluation or surgery? ☐ **Yes** ☐ **No** ☐ **I don't know**

What is your level of pain right now (with 1 being the least bothersome and 10 being severe)?_____

Any recent tests related to this problem? (Blood work, urine test, radiology examination) _____

_____

HEALTH MAINTANANCE

Have you had a Flu Shot within the last year? ☐ **Yes, (approximate date):** _____ ☐ **No**

Have you ever had a Pneumonia Vaccine? ☐ **Yes, (approximate date):** _____ ☐ **No**

When was your last Colonoscopy/Flex Sigmoid? (approximate date): _____ ☐ **Never**

PAST MEDICAL HISTORY-ILLNESSES OR HOSPITALIZATION (List with date first diagnosed)

☐ **Cancer** _____ ☐ **Hypertension** ☐ **Coronary Artery Disease/Heart Disease**

☐ **Diabetes Mellitus** ☐ **Congestive Heart Failure**

☐ **Other, please list:** _____

PAST SURGICAL HISTORY (FOR ANY MEDICAL PROBLEM) List any past surgeries and dates.

_____

_____

SOCIAL HISTORY

MARITAL STATUS: ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

WORK STATUS: ☐ **Currently working** ☐ **Unemployed** ☐ **Part-time** ☐ **Retired** ☐ **Student** ☐ **Disabled**

DO YOU SMOKE? ☐ **Yes** ☐ **No** **# PACKS** ____ **# YEARS** _____ ☐ **CIGARETTES** ☐ **CIGARS**

☐ **I quit Date stopped:** _____

DO YOU DRINK ALCOHOL? ☐ **Yes** ☐ **No If yes, how much?** ☐ **Occasionally** ☐ **3-4X per week** ☐ **Every day** ☐ **Other**_____

CAFFEINE INTAKE: ☐ **Yes** ☐ **No If yes, COFFEE #cups daily**_____ **TEA #cups daily**_____ **SODA #cups daily**_____

ARE YOU ON A SPECIAL DIET? ☐ **Yes** ☐ **No**

If yes, describe _____ ☐ **Weight loss** ☐ **Diabetic** ☐ **Low sodium** ☐ **Low carbohydrates**

SEXUAL HISTORY: ☐ **Active** ☐ **Inactive** ☐ **None**

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL OR OTHER PROCEDURES? ☐ **Yes** ☐ **No**

If yes, what do you take?_____ **If so, why?**_____

FAMILY HISTORY

ILLNESS	FATHER	MOTHER	SIBLING	GRANDPARENT		
Prostate cancer	☐	☐	☐	☐		
Breast cancer	☐	☐	☐	☐		
Colon cancer	☐	☐	☐	☐		
Colon Polyps	☐	☐	☐	☐		
Crohn's Disease	☐	☐	☐	☐		
Esophageal Cancer	☐	☐	☐	☐		
Gastric Cancer	☐	☐	☐	☐		
Heart Problems	☐	☐	☐	☐		
Liver Disease	☐	☐	☐	☐		
Pancreatic Cancer	☐	☐	☐	☐		
Skin Cancer	☐	☐	☐	☐		
Other	_____	_____	_____	_____	_____	_____
Family Members that are deceased	☐	☐	☐	☐		

REVIEW OF SYSTEMS

Do you presently have any of these problems? Check Yes or No.
Please explain any Yes answers in space provided.

Constitutional Symptoms
- Fever ☐Yes ☐ No
- Chills ☐Yes ☐ No
- Headache ☐Yes ☐ No
- Fatigue ☐Yes ☐ No
- Other_____

Eyes
- Blurred vision ☐Yes ☐ No
- Double vision ☐Yes ☐ No
- Glaucoma ☐Yes ☐ No
- Other_____

Ear/Nose/Throat/Mouth
- Ear Infection ☐Yes ☐ No
- Sore Throat ☐Yes ☐ No
- Sinus problems ☐Yes ☐ No
- Other_____

Cardiovascular
- Chest Pain ☐Yes ☐ No
- Varicose Veins ☐Yes ☐ No
- High blood pressure ☐Yes ☐ No
- Other_____

Respiratory
- Wheezing ☐Yes ☐ No
- Frequent cough ☐Yes ☐ No
- Shortness of Breath ☐Yes ☐ No
- Other_____

Gastrointestinal
- Abdominal pain ☐Yes ☐ No
- Nausea/vomiting ☐Yes ☐ No
- Indigestion/heartburn ☐Yes ☐ No
- Other_____

Genitourinary
- Urine retention ☐Yes ☐No
- Painful urination ☐Yes ☐No
- Urinary frequency ☐Yes ☐No
- Other_____

Musculoskeletal
- Joint Pain ☐Yes ☐ No
- Neck Pain ☐Yes ☐ No
- Back Pain ☐Yes ☐ No
- Arthritis ☐Yes ☐ No
- Other_____

Integumentary
- Skin rash ☐Yes ☐ No
- Jaundice ☐Yes ☐ No
- Persistent Itch ☐Yes ☐ No
- Other_____

Neurological
- Tremors ☐Yes ☐ No
- Dizzy Spells ☐Yes ☐ No
- Numbness/tingling ☐Yes ☐ No
- Headaches ☐Yes ☐ No
- Other _____

Psychologic
- Generally satisfied ☐Yes ☐ No
- Depression ☐Yes ☐ No
- Suicidal thoughts ☐Yes ☐ No
- Other_____

Endocrine
- Excessive thirst ☐Yes ☐ No
- Diabetes ☐Yes ☐ No
- Thyroid disease ☐Yes ☐ No
- Other_____

Hematologic/Lymphatic
- Swollen glands ☐Yes ☐ No
- Blood clotting problem ☐Yes ☐ No
- Other_____

Allergic/Immunologic
- Hay Fever ☐Yes ☐ No
- Food Allergies ☐Yes ☐ No
- Latex Allergy ☐Yes ☐ No
- Other _____

Reviewed by:_____ **Date:**_____

WOMEN ONLY – GYNECOLOGIC/OBSTETRIC HISTORY

Age at onset of periods_____ Frequency_____ Length _____

Pregnancies _____ Births _____ Miscarriages_____

Prolonged abnormal bleeding ☐ No ☐ Yes (Describe)_____

Leakage of urine ☐ No ☐ Yes (Describe)_____

Pelvic pain ☐ No ☐ Yes (Describe)_____

Abnormal discharge ☐ No ☐ Yes (Describe)_____

History of abnormal Pap test ☐ No ☐ Yes (Describe)_____

MIDLANTIC UROLOGY

IN ORDER TO PROVIDE SAFER AND MORE EFFECTIVE CARE, A COMPLETE LISTING AND UPDATE OF ALL OF YOUR MEDICATIONS IS REQUIRED

MEDICATION AND ALLERGY LIST

Patient's Name:_____ Date of Birth:_____

Medication	Dose (mg)	# of pills	How many times a day? (Circle the number)
Example: Tylenol	325	2	1 2 3 (4)
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4

❒ Check here if more medications are listed on the back of this form.
(List additional medications on back)

HERBAL/OVER THE COUNTER/SUPPLEMENTS

Medication	Dose (mg)	# of pills	How many times a day? (Circle the number)
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4

MEDICATION ALLERGIES AND REACTIONS:

Allergy	Reaction

LATEX ALLERGY YES NO If yes, reaction?_____