

MIDLANTIC UROLOGY-UROLOGY HEALTH SPECIALISTS

MEDICAL HISTORY FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

REASON FOR VISIT: _____

When did you first notice the problem? days ago weeks ago months ago other _____

Are your symptoms getting worse? _____ Is the problem intermittent or variable constant

Does the problem interfere with your normal activities? Yes No

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

Have you had this problem before? Yes No

Have you had prior urological evaluation or surgery? Yes No

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, x-rays) _____

PAST MEDICAL HISTORY

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcer disease |
| <input type="checkbox"/> Disc problems –neck/back | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Coronary heart disease/MI | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Heart valve disease | <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Elevated cholesterol | <input type="checkbox"/> Other mental health | What type? _____ |

PAST UROLOGIC HISTORY

- | | | |
|---|---|---|
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Urinary tract infections | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Injury |

PAST SURGICAL HISTORY List any past surgeries and dates

HEALTH MAINTANENCE

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

SOCIAL HISTORY

MARITAL STATUS: Married Single Widowed Separated Divorced

CHILDREN: Yes No How many? _____

WORK STATUS: Currently work Unemployed Part-time Retired Student Disabled

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

I quit Date stopped _____

DRINK ALCOHOL? Yes No If yes, how much? Occasionally 3-4x per week Daily

I quit Date stopped _____

CAFFEINE INTAKE: Yes No If yes? Coffee #cups daily____ Tea #cups daily____ Soda daily #_____

SPECIAL DIET? Yes No If yes? Weight loss Diabetic Low carb Vegan/Vegetarian

SEXUAL HISTORY: Active Inactive None

Method of contraception? Condoms? Yes No Other _____

FAMILY HISTORY

ILLNESS FATHER MOTHER SIBLING GRANDPARENT

Prostate cancer

Breast cancer

Colon cancer

Kidney stones

High blood pressure

Heart disease

Diabetes

Ovarian cancer

Other _____

Family Members that are deceased

REVIEW OF SYSTEMS

Do you have any problems related to the following systems? 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 _____

Musculoskeletal

- Joint pain Yes No
- Neck pain Yes No
- Back pain Yes No
- Leg pain when walk Yes No
- Other _____

Eyes

- Blurred vision Yes No
- Double vision Yes No
- Other _____

Integumentary

- Skin rash Yes No
- Jaundice Yes No
- Other _____

Ear/Nose/Throat/Mouth

- Ear infection Yes No
- Sore throat Yes No
- Sinus problems Yes No
- Other _____

Neurological

- Tremors Yes No
- Dizzy spells Yes No
- Numbness/tingling Yes No
- Other _____

Cardiovascular

- Chest pain Yes No
- Varicose veins Yes No
- Swollen legs Yes No
- Other _____

Psychologic

- Generally satisfied Yes No
- Depression Yes No
- Anxiety Yes No
- Other _____

Respiratory

- Wheezing Yes No
- Persistent cough Yes No
- Shortness of breath Yes No
- Other _____

Endocrine

- Excessive thirst Yes No
- Too hot or too cold Yes No
- Unexplained weight loss Yes No
- Other _____

Gastrointestinal

- Diarrhea Yes No
- Nausea/vomiting Yes No
- Indigestion/heartburn Yes No
- Constipation Yes No
- Other _____

Hematologic/Lymphatic

- Swollen glands Yes No
- Bleeding problems Yes No
- Other _____

Genitourinary

- Urine retention Yes No
- Painful urination Yes No
- Frequent urination Yes No
- Blood in urine Yes No
- Other _____

Allergic/Immunologic

- Seasonal allergies Yes No
- Food allergies Yes No
- Latex allergy Yes No
- Other _____

Reviewed by: _____

Date: _____

ADDITIONAL INFORMATION

MEN ONLY

Vasectomy Yes No Prostatitis Yes No Infertility Yes No
Epididymitis Yes No Enlarged prostate Yes No Impotence Yes No
Scrotal pain Yes No PSA blood test Yes No Penile lesions Yes No

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) _____

Endometriosis No Yes (Describe) _____

Fertility problems No Yes (Describe) _____

Abnormal discharge No Yes (Describe) _____

History of abnormal Pap test No Yes (Describe) _____

MIDLANTIC UROLOGY – UROLOGY HEALTH SPECIALISTS

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

MEDICATION AND ALLERGY LIST

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

PRESCRIPTIONS

Medication	Dose (mg)	# of pills	How many times a day? (Circle the number)
Example: Tylenol	325	2	1 2 3 4 <input checked="" type="radio"/>
			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
			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

DO YOU TAKE AN ANTIBIOTIC PRIOR TO DENTAL PROCEDURES? Yes No