The Urology Clinic
Patient Medical History Form

Patients Name_____DOB_____
Current: (WT)_____ (HT)_____BMI:_____ (date:_____)

Reason for visit_____

Referring physician:_____

Past Medical History: (circle all that apply)
Asthma, Bleeding Disorder, Bronchitis, Chest Pain, Depression, Diabetes, Emphysema, Gout, Heart Attack, Heart Disease, Heart Murmur, Heart Valve problems, High Blood Pressure, Irregular Heartbeat, Jaundice, Kidney Disease, Stroke, Thyroid Problems, Tuberculosis, Ulcers,
Cancer: (please list)_____
Other:_____

Past Surgical History: List personal past surgeries
_____
_____
_____
_____

Medications list name, dosage, frequency and route of administration this includes herbals, vitamins/minerals/dietary (nutriental) supplements, for addition documentation of medications/supplements please use attached medication form

1._____ 2._____ 3._____ 4._____

5._____ 6._____ 7._____ 8._____

9._____ 10._____ 11._____ 12._____

13._____ 14._____15._____16._____

Allergies to medication(s):_____

Circle any other allergies that apply to you.
Iodine, Latex, Shellfish, X-ray Dye, Other: (please list)_____

Past Family History:
(circle all that apply to your immediate family and indicate the family member/mother, father, sister brother)

Diabetes_____Heart Attack_____Heart Disease_____
High Blood Pressure_____Kidney Disease_____Stroke_____
Cancer: (please explain)_____

Social History:
Do you smoke? YES/NO If so, how much and for how long?_____
If you quit, how long ago?_____
Do you drink alcoholic beverages? YES/NO If so, how much and how often?_____

Occupation:_____

***COMPLETE BOTH SIDES OF THIS FORM**

Do you have or have you had any problems related to the following?

Please circle Yes or No. PLEASE EXPLAIN ALL YES ANSWERS

Update and reviewed_____/Update and reviewed_____/Update and reviewed_____

Constitutional Symptoms:	
Fever	**YesNo_____**
Weight loss or gain	**Yes/No_____**
Eyes:	
Blurred or double vision	**Yes/No_____**
Cataracts	**Yes/No_____**
Glaucoma	**Yes/No_____**
Respiratory:	
Wheezing	**Yes/No_____**
Frequent cough	**Yes/No_____**
Shortness of breath	**Yes/No_____**
Asthma/Bronchitis/ Emphysema/ Pneumonia	**Yes/No_____**
Tuberculosis	**Yes/No_____**
	Yes/No_____
Genitourinary:	
Frequent urination	**Yes/No_____**
Painful urination	**Yes/No_____**
Nocturia (getting up to urinate at night)	**Yes/No_____**
Blood in urine	**Yes/No_____**
Incontinence (urinary leakage)	**Yes/No_____**
Urinary tract infections	**Yes/No_____**
Slow stream	**Yes/No_____**
Integumentary:	
Skin rash	**Yes/No_____**
Hematologic/Lymphatic:	
Enlarged lymph nodes	**Yes/No_____**
Bleeding problems	**Yes/No_____**
History of cancer	**Yes/No_____**
Cardiovascular:	
Chest pain	**Yes/No_____**
Rheumatic fever	**Yes/No_____**
Rapid heart beat	**Yes/No_____**
High blood pressure	**Yes/No_____**
Pain in legs (calf) with walking	**Yes/No_____**
Gastrointestinal:	
Abdominal pain	**Yes/No_____**
Nausea and or vomiting	**Yes/No_____**
Rectal bleeding	**Yes/No_____**
Diarrhea/Constipation	**Yes/No_____**
Hepatitis	**Yes/No_____**
Musculoskeletal:	
Joint pain	**Yes/No_____**
Back pain	**Yes/No_____**
Arthritis	**Yes/No_____**
Neurologic:	
Seizures	**Yes/No_____**
Paralysis	**Yes/No_____**
Tingling	**Yes/No_____**
Endocrine:	
Thyroid problems	**Yes/No_____**
Diabetes Mellitus	**Yes/No_____**
Increase thirst/Heat or cold intolerance	**Yes/No_____**
Excessive urination	**Yes/No_____**