The Urology Clinic

Medical History Form

Patients Name: _____**DOB:**_____
Email Address: _____
Date Completed_____
Current: **(WT)** _____ **(HT)** _____ (BMI) _____
Vital Signs: **(BP)** _____ **(P)** _____ **(R)** _____ **(T)** _____
Reason for visit: _____
Do you have an advance directive: ❑Yes ❑No / Name: _____
Relationship to above name: _____
Do you wish information about directives: ❑Yes ❑ No
Referring Provide or Primary Care 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(s), dosage, frequency (this includes herbals, vitamins/minerals/dietary and nutrient supplements)

Drug Name	Dose	Frequency

Allergies to medication(s):_____
Please list if allergic to Iodine, Latex, Shellfish, X-ray Dye, Other: _____

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: (type) _____
Social History:
Do you smoke? ❑ Yes ❑ No / did you smoke? ❑ Yes ❑ No / If YES, for how long? _____
Interested in counseling on stopping smoking ❑ Yes ❑ NO

Do you drink alcoholic beverages? ❑Yes ❑No / If YES, how much and how often? _____
Occupation: _____
***COMPLETE BOTH SIDES OF THIS FORM**
Do you have or have you had any of the following problems.
Please circle YES or NO and explain all YES answers
Updated and reviewed_____/Update and reviewed_____/Update and reviewed_____

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

Endocrine: **Thyroid problems** **Diabetes Mellitus** **Increase thirst/Heat or cold intolerance** **Excessive urination**	 **Yes/No**_____ **Yes/No**_____ **Yes/No**_____ **Yes/No**_____

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