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

- ☐ Arthritis
- ☐ Disc problems –neck/back
- ☐ Coronary heart disease/MI
- ☐ Irregular heart beat
- ☐ Heart valve disease
- ☐ High blood pressure
- ☐ Blood disorder
- ☐ Circulation problems
- ☐ Elevated cholesterol
- ☐ Asthma
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Seizures
- ☐ CVA/Stroke
- ☐ Parkinson's disease
- ☐ Depression
- ☐ Anxiety
- ☐ Other mental health
- ☐ Ulcer disease
- ☐ Diverticulitis
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Obesity
- ☐ Gout
- ☐ Cancer

What type? _____

PAST UROLOGIC HISTORY

- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Urinary tract infections
- ☐ Sexually transmitted disease
- ☐ Urinary incontinence
- ☐ 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_____

Eyes
- Blurred vision ☐Yes ☐No
- Double vision ☐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
- Swollen legs ☐Yes ☐No
- Other_____

Respiratory
- Wheezing ☐Yes ☐No
- Persistent cough ☐Yes ☐No
- Shortness of breath ☐Yes ☐No
- Other_____

Gastrointestinal
- Diarrhea ☐Yes ☐No
- Nausea/vomiting ☐Yes ☐No
- Indigestion/heartburn ☐Yes ☐No
- Constipation ☐Yes ☐No
- Other_____

Genitourinary
- Urine retention ☐Yes ☐No
- Painful urination ☐Yes ☐No
- Frequent urination ☐Yes ☐No
- Blood in urine ☐Yes ☐No
- Other_____

Musculoskeletal
- Joint pain ☐Yes ☐No
- Neck pain ☐Yes ☐No
- Back pain ☐Yes ☐No
- Leg pain when walk ☐Yes ☐No
- Other_____

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

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

Psychologic
- Generally satisfied ☐Yes ☐No
- Depression ☐Yes ☐No
- Anxiety ☐Yes ☐No
- Other_____

Endocrine
- Excessive thirst ☐Yes ☐No
- Too hot or too cold ☐Yes ☐No
- Unexplained weight loss ☐Yes ☐No
- Other_____

Hematologic/Lymphatic
- Swollen glands ☐Yes ☐No
- Bleeding problems ☐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 ◯
			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**