Urologic Surgeons

New Patient History Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

*Last Name*__________________________ *First Name*____

*DOB*______________________________*Date*____

Chief Complaint/Reason for visit: ____

Medical History

Please Circle if you have ever had any of the following medical problems

Vision Problems	Asthma	Emphysema	Sinus Problems	Hypertension
Arthritis	Bronchitis	Anemia	Tuberculosis	Heart Disease
Diabetes	Stroke	Colitis/Chron's	Seizures	Sickle cell
Cancer	Gout	Hepatitis/Jaundice	Thyroid Disease	Heart Murmur
Mumps	Migraines	Herpes	Nose Bleeds	Depression
Hearing Problems	Bleeding Disorder	None		

Current Medications:

____

____

____

____

Allergies to Medications :

____

____

____

Family History

Please Circle any of the following medical problems that pertain to your family:

Prostate Cancer	Bladder Cancer
Kidney Stone Disease	Renal Disease
Bleeding Disorder	Cardiovascular Disease
Kidney Cancer	Stroke
High Blood Pressure	Diabetes
Asthma/Hay Fever	None
Other:	

Social History

Smoke? Yes No If yes, # of Packs per day: _____# of years_____When did you stop smoking? ____
Alcohol? Yes No If yes, how many drinks per week? _____
Occupations? ____
Coffee- How much? _____ Tea-How much? ______ Soda-How much? _________
Have you ever used recreational drugs? (i.e. marijuana, cocaine) If yes, what/when:
____
____
DomesticViolence?____
____

Surgical History

Please list all of your past surgeries:

____

____

____

Review of Systems

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

Circle Yes or No

Constitutional Symptoms
Fever Y N
Chills Y N
Headache Y N
Other ____________________

Eyes
Blurred Vision Y N
Double Vision Y N
Pain Y N
Other______________________

Allergic/Immunologic
Hay Fever Y N
Drug Allergies Y N
Other_______________________

Neurological
Tremors Y N
Dizzy spells Y N
Numbness/Tingling Y N
Other_______________________

Endocrine
Excessive Heat Y N
Too hot/cold Y N
Tired/Sluggish Y N
Other________________________

Gastrointestinal
Abdominal Pain Y N
Nausea/Vomiting Y N
Indigestion/heartburn Y N
Other__________________________

Cardiovascular
Chest Pain Y N
Varicose Y N
High blood Pressure Y N
Other____________________________

Integumentary
Skin Rash Y N
Boils Y N
Persistent Itch Y N
Other________________________

Musculoskeletal
Joint Pain Y N
Neck Pain Y N
Back Pain Y N
Other__________________________

Ear/Nose/Throat/Mouth
Ear Infection Y N
Sore Throat Y N
Other____________________________

Genitourinary
Urine Retention Y N
Painful Urination Y N
Urinary Frequency Y N
Other____________________________

Respiratory
Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N
Other____________________________

Hematological/Lymphatic
Swollen glands Y N
Blood Clotting Problems Y N
Other____________________________

Psychologic
Are you generally satisfied with your life? Y N
Do you feel severely depressed ? Y N
Have you considered suicide ? Y N
Other__________________________________

The above information is correct.

Patient Signature: ______________________________Date: _____________________

I have reviewed both sides of this medical history form

Physician Signature:________________________ Date:_________________________