



Health History Form: Urology

Patient Name: _____ Date of Birth: _____

Sex (please check): Male Female Family Doctor: _____

Referring Doctor: _____

Please check all that apply about your PERSONAL PAST medical history:

Cardiovascular: Heart Attack Heart Murmur High Blood Pressure
Heart Valve Problems Irregular Heart Beat Coronary Artery Disease
Deep Vein Thrombosis Bleeding Tendency Congestive Heart Failure

Endocrine: Insulin Dependent Diabetes HYPOthyroid Hyperthyroid
Diet Controlled Diabetes

Gastro-intestinal: Acid Reflux Irritable Bowel Peptic Ulcer Diarrhea
Constipation Diverticulitis Nausea Vomiting

Genito-urinary: Kidney Stones Bladder Stones Frequent UTI's BPH
Prostatitis Elevated PSA Blood in urine Incontinence
Overactive Bladder Post-void Dribbling Erectile Dysfunction
Arthritis Low Back Pain Fibromyalgia Gout Unsteady Gait
Joint Replacement _____

Neurologic: Stroke Migraines Parkinson's Chronic Headaches
Multiple Sclerosis Seizures Polio Spinal Cord Injury Spina Bifida

Pulmonary: Emphysema Asthma COPD Sleep Apnea Bronchitis

Hematology/ Oncology: Anemia Leukemia Prostate Cancer Testicle Cancer
Kidney Cancer Bladder Cancer Colorectal Cancer
Uterine Cancer Ovarian Cancer Lymphoma
Hepatitis HIV Aids

Other: _____

CURRENT MEDICATIONS: (List name and dosage of medications you are currently taking)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: _____

FAMILY MEDICAL HISTORY:

Prostate Cancer	Family Member:_____
Kidney Cancer	Family Member:_____
Bladder Cancer	Family Member:_____
Colon Cancer	Family Member:_____
Bleeding Disorder	Family Member:_____
Polycystic Kidney Disease	Family Member:_____
Kidney Failure	Family Member:_____
Kidney or Bladder Stones	Family Member:_____
Urinary Tract Infections	Family Member:_____
Interstitial Cystitis	Family Member:_____

SOCIAL HISTORY:

Ever Smoke: Yes No If yes, packs/day _____ Years Smoked _____ If quit, when _____

Smokeless Tobacco: Yes No If yes, how much _____ Years used _____ If quit, when _____

Alcohol: Yes No If yes, how much _____ Years used _____ If quit, when _____

Do you take antibiotics before dental procedures? Yes No

SYMPTOMS: (Please check if you are currently experiencing or have experienced in the past)

Constitutional: Chronic Fevers Poor Appetite Chills/ Night Sweats Bruises Easily

Neurologic: Migraines Seizures Tremors

Eyes: Blurred Vision Double Vision Eye Pain

Endocrine: Excessive Thirst Cold/Heat Intolerance Tired/ Sluggish Decreased Libido

Allergic/ Immunologic: Animal Environmental Food Seasonal

Gastro-Intestinal: Constipation Diarrhea Indigestion/Heartburn Abdominal Pain
Nausea Vomiting

Cardiovascular: Chest pain Vascular problems Palpitations

Skin: Skin rashes Changing moles Pigment Changes

Musculoskeletal: Joint pain Neck pain Back pain

Ear/Nose/Throat/Mouth: Hearing loss Sinus infection Difficulty swallowing

Respiratory: Shortness of breath Wheezing Chronic cough

Hematologic/Lymphatic: Swollen glands Blood clots Bleeding problems

Psychological: Depression Anxiety

Genitourinary: Weak stream Awaken to urinate Incomplete emptying of bladder
Dribbling Burning with urination Blood in urine

I hereby authorize consent for treatment and release of any necessary information acquired in the course of examination and treatment by my physician for processing of my medical exam.

Signature of patient/ Insured/ Legal Guardian

Date

DO YOU TAKE ANY OF THE FOLLOWING MEDICATIONS – IF SO, PLEASE CHECK

Coumadin Xarelto Pradaxa Eliquis Aggrenox Aspirin Aleve

Meloxicam Plavix Vitamin E Fish Oil Naprosyn/ Naproxen

DO YOU HAVE ANY OF THE FOLLOWING – IF SO, PLEASE CHECK

Artificial Joint Pacemaker Defibrillator Insulin Pump Pain Pump

Sleep Apnea requiring C-Pap or Bipap Pain pump Any other foreign body

PAST SURGERIES – PLEASE CHECK ALL THAT APPLY

Kidney Stone Cholecystectomy (Gallbladder) Kidney Removal (Nephrectomy)

Heart Surgery Specific Kind _____ Colon Resection Hernia

Hysterectomy Thyroid Lung Hip/Knee/Back Specific Kind _____

Other _____