IRMC
PHYSICIAN GROUP
THE COMMUNITY'S CHOICE

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_____