

Urology Associates

Patient History Form

Please fill out the following demographic information.

Name: _____	Date ____/____/____
Signature: _____	Date of Birth ____/____/____
Age: _____	
Did a physician refer you? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, who? _____	

Chief Complaint: *What is the main reason for your visit to the doctor today?*

Allergies: *Please list any medication allergies you have or check none.* none

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____

Current Medications: *Please list any medications you are taking or check none. Please include any over the counter products, herbs, or supplements.* none

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____
7. _____	8. _____	9. _____

Medical History: *Please list any medical problems you have had or currently have.* none

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____
7. _____	8. _____	9. _____

Surgical History: *Please list any surgical procedures you have had and approximate dates.* none

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____
7. _____	8. _____	9. _____

Family History: *Please list any illness that your immediate family members have or had. Please include if they have ever had kidney, bladder, or prostate problems.*

Father	_____
Mother	_____
Sisters	_____
Brothers	_____

Social History: *Please answer the following questions.*

Do you smoke cigarettes? Yes No *If yes, how many packs per day?* _____

Do you drink alcohol? Yes No *If yes, how many drinks daily/weekly?* _____

Are you currently working? Yes No *If yes, what is your occupation?* _____

Are you married? Yes No

Are you on a special diet? Yes No *If yes, what kind?* _____

Do you exercise regularly? Yes No

Do you have any children? Yes No *If yes, how many?* _____

Do you drink caffeine? Yes No *If yes, what and how much?* _____

General Health Review: *Please circle if you have experienced any of the following symptoms within the last few months.*

General

- Unexplained weight loss/gain
- Fevers/Chills/Sweats
- Difficulties sleeping
- Change in appetite

Skin

- Unexplained rash
- History of skin cancer

Head

- History of headaches
- History of head trauma

Eyes

- Changes in vision

Ears

- Hearing changes
- Ringing in the ears
- Dizziness/Vertigo

Nose

- Runny nose
- Bloody nose
- Nasal congestion

Throat

- Hoarseness of voice
- Sore throat
- Difficulty swallowing

Neck

- Neck stiffness
- Lumps/Bumps in neck

Lungs

- Shortness of breath
- Wheezing
- History of exposure to pollutants:
- Cough
- Pain with breathing

Cardiovascular

- Chest pain
- Palpitations/skipped beats
- History of heart murmur
- Dizziness/Fainting spells
- Fluid in legs/feet
- Unable to sleep flat at night
- Waking up in night gasping for air
- Pain in legs with activity

Genitourinary

- Frequency of urination
- Burning with urination
- Blood in urine
- Urinary urgency
- Urine accidents
- Weak urine stream

Women's Health

- Age of first period _____
- I reached menopause at age _____
- Last menstrual period _____
- Irregular menstrual periods
- Vaginal discharge/spotting/unusual odor
- Currently pregnant, _____ months
- Pain with intercourse
- History of sexually transmitted diseases
- Breast lumps/bumps/nipple discharge
- Breast pain

Men's Health

- Erectile dysfunction
- Difficulty with ejaculation
- Skin lesions on penis
- Blood in sperm
- History of prostrate problems
- Urgency/Frequency/Burning w/ urination
- Premature ejaculation
- History of sexually transmitted diseases

Behavioral Health

- Mood changes
- Anxiety/Depression
- Insomnia
- Suicidal ideation

Neurological Health

- Numbness/tingling sensations in extremities
- Decrease strength in extremities
- Seizures
- History of stroke
- Neurological disease

Musculoskeletal

- Muscle weakness/pain
- Joint pain/redness/swelling
- Back/neck pain

Office Use Only

I have reviewed this intake form with the above listed patient in its entirety.

Clinician/Physician Signature
