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☐ No☐ 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 ccupation?*_____
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 ***Clinician/Physician Signature***
I have reviewed this intake form with the above listed patient in its entirety.
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