New Urology Patient History

Name: _____
Date: ___/___/___

Reason for Visit: _____
Primary Care Doctor: _____

PAST MEDICAL HISTORY (circle)

Cataract/Glaucoma
Seizure/Head trauma
High blood pressure
Thyroid problems
Bleeding problems
Heart Failure
Urinary Tract Infections
COPD/emphysema
Depression
Stroke
Diabetes
High Cholesterol
Reflux/Heart Burn
Blood Clots
Heart Attack
Kidney Stones
Asthma
Prostate problem
Cancer type _____
Other _____

PAST SURGICAL HISTORY (circle)

Cataracts
Heart Surgery/Stent
AAA repair
Appendectomy
Spinal Surgery
Kidney stone
C-section
Thyroidectomy
Pacemaker
Gallbladder
Hernia
Orthopedic
Bladder Tumor
Hysterectomy
Prostate Surgery (type) _____
Other _____

FAMILY HISTORY (circle)

Testicular Cancer
Prostate Cancer
Kidney Cancer
Bladder Cancer
Kidney Stones
Other Cancer _____
Other_____

SOCIAL HISTORY (circle)

Smoking
Never Smoked
Former Smoker
Quit date _____
Current smoker
____ packs per day

Alcohol
rare, occasional, daily

Caffeine
coffee, tea, soda

Drug use
type _____

Occupation:_____ **Marital Status:** _____

ALLERGIES TO MEDICATIONS

Yes No

If yes, please list:

_____ _____
_____ _____

MEDICATIONS (List)

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

TODAY DO YOU HAVE ANY SYMPTOMS?
(circle any that apply)

General
Fever
Chills
Weakness
Weight Loss

Eyes, Nose, Throat
Sore Throat
Sinus Drainage
Ear ache/Drainage
Blurred Vision
Loss of Hearing

CARDIAC
Chest Pain
Palpitations
Irreg. Heart rate

RESPIRATORY
Cough
SOB
Wheezes

UROLOGY
Trouble starting to urinate
Frequent urination
Blood in urine
Urinary tract infection
Burning on urination
Loss of urine (leaking)
Sexually transmitted disease
Waking up > 2 times per night to urinate

GI
Nausea
Vomiting
Diarrhea
Abdominal Pain

HEME
Bleeding
Blood clots

PSYCH
Depression
Anxiety

NEUROLOGY
Headaches
Vertigo
Seizures

SKIN
Rashes

MSK
Bone/Joint pain