New Urology Patient History

Name: _________________
Date: ___/___/___

Reason for Visit: ______________________
Primary Care Doctor: ___________________

PAST MEDICAL HISTORY (circle)

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

Cancer type _________________
Other ___________________________________

PAST SURGICAL HISTORY (circle)

Cataracts	Thyroidectomy
Heart Surgery/Stent	Pacemaker
AAA repair	Gallbladder
Appendectomy	Hernia
Spinal Surgery	Orthopedic
Kidney stone	Bladder Tumor
C-section	Hysterectomy

Prostate Surgery (type) ______________________
Other ____________________________________

FAMILY HISTORY (circle)

Testicular Cancer

Prostate Cancer	Bladder Cancer
Kidney 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