

**UROLOGY HEALTH SPECIALISTS, LLC**

**PATIENT INFORMATION AND HISTORY**

**HISTORY OF PRESENT ILLNESS**

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**REASON FOR VISIT:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**When did you first notice the problem?**  2 days ago  2 weeks ago  Other \_\_\_\_\_

**Are your symptoms getting worse?** \_\_\_\_\_

**Is the problem**  constant or variable  dull then sharp  very sharp then leaves  always

**Does the problem interfere with your normal activities?**  Yes  No (If yes, explain) \_\_\_\_\_

\_\_\_\_\_

**Is there anything else occurring at the same time?**  Yes  No (If yes, explain) \_\_\_\_\_

\_\_\_\_\_

Nausea  Rash  Headache  Fever  Other \_\_\_\_\_

**Have you had this problem before?**  Yes  No  I don't know

**Have you had prior urological evaluation or surgery?**  Yes  No  I don't know

**What is your level of pain right now (with 1 being the least bothersome and 10 being severe)?** \_\_\_\_\_

**Any recent tests related to this problem? (Blood work, urine test, radiology examination)** \_\_\_\_\_

\_\_\_\_\_

**PAST SURGICAL HISTORY (FOR ANY MEDICAL PROBLEM) List any past surgeries and dates.**

\_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY-ILLNESSES OR HOSPITALIZATION (List with date first diagnosed)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DO YOU HAVE ANY FOOD OR DRUG ALLERGIES?**  Yes  No  
 (Please refer to page 5 to list any allergies and allergic reactions)

**DO YOU SMOKE?**  Yes  No **If Yes, how much?/years?** \_\_\_\_\_  
 I quit **Date stopped** \_\_\_\_\_

**DO YOU DRINK ALCOHOL?**  Yes  No

**If yes, how much?**  Occasionally  3-4X per week  Every day  Other \_\_\_\_\_

**ARE YOU ON A SPECIAL DIET?**  Yes  No

**If yes, describe** \_\_\_\_\_  Weight loss  Diabetic  Low sodium  Low carbohydrates

**DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL OR OTHER PROCEDURES?**  Yes  No

**If yes, what do you take?** \_\_\_\_\_ **If so, why?** \_\_\_\_\_

**FAMILY HISTORY**

| <b>ILLNESS</b>                   | <b>FATHER</b>            | <b>MOTHER</b>            | <b>BROTHER(S)</b>        | <b>SISTER(S)</b>         | <b>GRANDFATHER</b>       | <b>GRANDMOTHER</b>       |
|----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Prostate cancer                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast cancer                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Colon cancer                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Colon Polyps                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crohn's Disease                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Esophageal Cancer                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gastric Cancer                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Problems                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Disease                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pancreatic Cancer                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin Cancer                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other                            | _____                    | _____                    | _____                    | _____                    | _____                    | _____                    |
| Family Members that are deceased | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other family history information: \_\_\_\_\_

## REVIEW OF SYSTEMS

**Do you now or have you had any problems related to the following systems? Check Yes or No.**

Please explain any Yes answers in space provided.

### Constitutional Symptoms

Fever  Yes  No  
Chills  Yes  No  
Headache  Yes  No  
Other \_\_\_\_\_

### Integumentary

Skin rash  Yes  No  
Boils  Yes  No  
Persistent itch  Yes  No  
Other \_\_\_\_\_

### Eyes

Blurred vision  Yes  No  
Double vision  Yes  No  
Pain  Yes  No  
Other \_\_\_\_\_

### Musculoskeletal

Joint pain  Yes  No  
Neck pain  Yes  No  
Back pain  Yes  No  
Other \_\_\_\_\_

### Allergic/Immunologic

Hay Fever  Yes  No  
Drug allergies  Yes  No  
Other \_\_\_\_\_

### Ear/Nose/Throat/Mouth

Ear infection  Yes  No  
Sore throat  Yes  No  
Sinus problems  Yes  No  
Other \_\_\_\_\_

### Neurological

Tremors  Yes  No  
Dizzy spells  Yes  No  
Numbness/tingling  Yes  No  
Other \_\_\_\_\_

### Genitourinary

Urine retention  Yes  No  
Painful urination  Yes  No  
Urinary frequency  Yes  No  
Other \_\_\_\_\_

### Endocrine

Excessive thirst  Yes  No  
Too hot/cold  Yes  No  
Tired/sluggish  Yes  No  
Other \_\_\_\_\_

### Respiratory

Wheezing  Yes  No  
Frequent cough  Yes  No  
Shortness of breath  Yes  No  
Other \_\_\_\_\_

### Gastrointestinal

Abdominal pain  Yes  No  
Nausea/vomiting  Yes  No  
Indigestion/heartburn  Yes  No  
Other \_\_\_\_\_

### Hematologic/Lymphatic

Swollen glands  Yes  No  
Blood clotting problem  Yes  No  
Other \_\_\_\_\_

### Cardiovascular

Chest pain  Yes  No  
Varicose veins  Yes  No  
High blood pressure  Yes  No  
Other \_\_\_\_\_

### Psychologic

Are you generally satisfied with your life?

Yes  No

Do you feel severely depressed?  Yes  No

Have you considered suicide?  Yes  No

Other \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

**WOMEN ONLY – GYNECOLOGIC/OBSTETRIC HISTORY**

Age at onset of periods \_\_\_\_\_ Frequency \_\_\_\_\_ Length \_\_\_\_\_

Pregnancies \_\_\_\_\_ Births \_\_\_\_\_ Miscarriages \_\_\_\_\_

Prolonged abnormal bleeding  No  Yes (Describe) \_\_\_\_\_

Leakage of urine  No  Yes (Describe) \_\_\_\_\_

Pelvic pain  No  Yes (Describe) \_\_\_\_\_

Abnormal discharge  No  Yes (Describe) \_\_\_\_\_

History of abnormal Pap test  No  Yes (Describe) \_\_\_\_\_

