

CONFIDENTIAL MEDICAL HISTORY

Please PRINT and Complete other side of page. All information is confidential. Today's date ___/___/___

Patient's Full Name _____ Birth date ___/___/___

Height _____ (ft/in.) **Weight** _____ (lb.) **Primary Care Physician** _____

Please answer all questions to the best of your ability; give the dates and names of doctors who treated you.

Chief Complaint What specific problems are you seeing the doctor for today? .

Include location, severity, duration, timing, and associated signs & symptoms.

Allergies List any known to medications: _____ NONE

Medications List all (with dosage) you are taking, including over-the-counter medications. NONE

1	4	7
2	5	8
3	6	9

Surgeries List all you have had and when they were done. NONE

1	4	7
2	5	8
3	6	9

Anesthesia Did you have problems with any anesthesia? NO If YES, explain _____

Bleeding Problems Do you or any family member have bleeding problems? NO If YES, explain _____

Medical Conditions or Hospitalizations (asthma, diabetes, heart disease, stroke, high blood pressure) NONE

1	4	7
2	5	8
3	6	9

Women's OB/GYN History How many times pregnant? _____ How many live births? _____

Are you pregnant now? YES NO When was your last menstrual period? _____ Previous one? _____

Social History Marital status: S M D W **Religion** _____

How many children have you had? Male ___ Female ___ NONE

Brothers _____ Sisters _____ Educational level (highest grade achieved) _____ (12 = senior high school)

Occupation Current: _____ Past: _____

Habits Do you use any of the following? (*Circle Never, NO or YES*)

Tobacco (smoke/chew)? Never YES Currently? NO If YES ever, how much _____

Alcohol in the past? Never YES Currently? NO If YES ever, how much _____

Recreational drugs? Never YES Currently? NO If YES ever, describe _____

Family Medical Problems List any that have occurred. _____ NONE

Parents' age (or age at death and cause.) Mom _____ Dad _____

Updated (date) _____

Initials: _____

Please complete other side of page also →

Urology Clinic Genito-Urinary Review of Systems

Pt. name _____

Mark the box with any symptoms you are having with this illness. **Please complete other side of page also** →

- | | | |
|--|---|--|
| <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Problems with erections | <input type="checkbox"/> Enuresis, nighttime bedwetting |
| <input type="checkbox"/> Dysuria, pain or burning during urination / voiding | <input type="checkbox"/> Lesions in the genital area | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Small voided volumes | <input type="checkbox"/> Discharge from the urethra | MALE: |
| <input type="checkbox"/> Feeling of urgent urination, urgency | <input type="checkbox"/> Infertility | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Hematuria, red or bloody urine | <input type="checkbox"/> Problems emptying the bladder, urinary retention | FEMALE: |
| <input type="checkbox"/> Cloudy or foul-smelling urine | <input type="checkbox"/> Hesitancy, slow starting stream | <input type="checkbox"/> Cystocele, fallen bladder |
| <input type="checkbox"/> Suprapubic or lower abdominal pain | <input type="checkbox"/> Long voiding time | <input type="checkbox"/> Rectocele |
| <input type="checkbox"/> Strangury, pain at end of urination / voiding | <input type="checkbox"/> Stricture of urethra | <input type="checkbox"/> Uterine prolapse |
| <input type="checkbox"/> Air in urine | <input type="checkbox"/> Kidney stones (family too) | <input type="checkbox"/> Difficult births |
| <input type="checkbox"/> Relationship between sex & infection | <input type="checkbox"/> Flank pain | <input type="checkbox"/> Discharge from the vagina |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Pain radiating to the groin | <input type="checkbox"/> Relationship between symptoms & menses |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Incontinence, leakage of urine | ***** |
| | <input type="checkbox"/> Nocturia: Do you get up at night to void? If so, how many times? _____ | <input type="checkbox"/> Any previous urologic evaluation? If so, why? _____ |

Medical Review of Symptoms

Do you have now, or have you had, any problem related to the following?
Circle Yes or No.

Please explain any YES answers.

Constitutional Symptoms

- | | |
|-------------|-----|
| Fever | Y N |
| Chills | Y N |
| Headache | Y N |
| Weight loss | Y N |

Gastrointestinal

- | | |
|-------------------------|-----|
| Abdominal pain | Y N |
| Nausea / vomiting | Y N |
| Indigestion / heartburn | Y N |
| Jaundice, hepatitis | Y N |

Endocrine

- | | |
|-------------------|-----|
| Excessive thirst | Y N |
| Too hot | Y N |
| Too cold | Y N |
| Tired or sluggish | Y N |

Musculoskeletal

- | | |
|------------|-----|
| Joint pain | Y N |
| Neck pain | Y N |
| Back pain | Y N |

Hematologic/Lymphatic

- | | |
|-------------------------|-----|
| Swollen glands | Y N |
| Anemia, low blood count | Y N |
| Blood clots in legs | Y N |

Ear/Nose/Throat/Mouth

- | | |
|----------------|-----|
| Ear infection | Y N |
| Sore throat | Y N |
| Sinus problems | Y N |

Neurological

- | | |
|-------------------|-----|
| Tremors | Y N |
| Dizzy spells | Y N |
| Numbness/tingling | Y N |
| Stroke | Y N |

Integumentary

- | | |
|-----------------|-----|
| Skin rash | Y N |
| Boils | Y N |
| Persistent itch | Y N |

Respiratory

- | | |
|---------------------------|-----|
| Wheezing, asthma | Y N |
| Frequent or chronic cough | Y N |
| Shortness of breath | Y N |

Eyes

- | | |
|----------------|-----|
| Blurred vision | Y N |
| Double vision | Y N |
| Pain | Y N |
| Glaucoma | Y N |

Cardiovascular

- | | |
|----------------------|-----|
| Chest pain | Y N |
| Heart attack | Y N |
| Heart failure | Y N |
| Irregular heart beat | Y N |
| Heart murmur | Y N |
| Varicose veins | Y N |
| High blood pressure | Y N |

Psychologic

- | | |
|-------------------------------------|-----|
| Feel severely depressed? | Y N |
| Generally satisfied with your life? | Y N |

Allergic/Immunologic

- | | |
|-----------|-----|
| Hay fever | Y N |
|-----------|-----|

Please complete other side →