Date: ____________________ Chart #: ___________

PATIENT HISTORY FORM - ADULT

Welcome to Urology Associates, P.C. This questionnaire is intended to be a COMPLETE account of your medical history. Please answer completely, including details and dates, if known. Incomplete answers to these questions could lead to improper treatment.

Patient Name: ________________________________ **Nickname:** ____________ **D.O.B:** __________ **Age:** _____

Referring Dr.: ______________________________ **Primary Care Dr.:** ________________________________

MEDICAL HISTORY **Height:** ______ **ft** _______ **in** **Weight:** ____________ **lbs** **Temp:** __________

Past Medical History:

__High Blood Pressure __Ulcers __Emphysema __Thyroid Problems __Back Pain

__Heart Attack __Kidney Stones __Diabetes __Gastric reflux __Difficulty Urinating

__Heart Disease __Kidney Failure __Gout __Arthritis __Recurring UTI

__Pacemaker __Colon problems __Glaucoma __Hepatitis

__Stroke/TIA __Neuropathy __Seizures __Liver Disease

Urologic Problems ____

Other Medical Problems ____

PAST SURGICAL HISTORY

__Brain __Chest __Hernia __Intestine __Fallopian Tubes __Prostate

__Sinus __Breast __Stomach __Kidney __Ovaries __Vasectomy

__Thyroid __Heart __Appendix __Bladder __Penis __Hip/Knee

__Lung __Gall Bladder __Pancreas __Uterus __Testes __Back

Other Surgeries____

ALLERGIES

Medication Allergies____

__Latex __Iodine __Shellfish

CURRENT MEDICATIONS ____I currently take no medications.

List Medications with dose

1.__________________ ________ 3_________________________ 5 _________________________

2._________________________ 4 _________________________ 6 _________________________

Additional medications____

SOCIAL HISTORY

Marital Status: ________ Single ________Married ________ Divorced ________Separated ________Widowed

Alcohol use ______________________ Caffeine use ______________________ Cigarettes ___________ packs per day

___Non-Smoker Quit smoking ____________years

Date: ____________________ Chart #: ___________

Patient Name: ________________________________

FAMILY HISTORY

__No Changes to Family History

__Bladder Cancer	__Diabetes	__Kidney Disease	__osteoporosis	__Urethral stenosis
__Prostate Cancer	__Heart Disease	__Kidney Disease	__Polycystic Kidney Disease	__UTI
__Kidney Cancer	__Hypertension	__Liver Disease	__Thyroid	

REVIEW OF SYSTEMS

__Fever	__Swollen Glands	__Nausea	__Fatigue	__Cough	__Vomiting
__Rash	__Chills	__Chest Pain	__Itching	__Constipation	__Blood in urine
__Diarrhea	__Bleed easily	__Sweating	__Dizziness	__Wight Loss	__Shortness of Breath

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(For Office Use Only)

ASSESMENT OF PLAN

__Flow Rate	__Bladder Scan	__UA with micro	___Culture	__Cytology	__Lupron	__BCG
__Intron A	__Mitomycin					