UROLOGICAL SURGICAL ASSOCIATES

PATIENT HISTORY FORM

DATE: _____ ACCOUNT #: _____

NAME: _____ DATE OF BIRTH: _____ AGE: _____

MEDICAL DOCTOR: _____

REASON FOR YOUR VISIT TODAY (HPI)

_____

_____

FEMALES ONLY

LMP _____
Paragravida _____
B.C. _____
Menopause _____
Hysterectomy _____

YOUR SYMPTOMS

DYSURIA
FREQUENCY
INCONTINENCE
SEXUAL PROBLEMS
FEVER
HEMATURIA
NOCTURIA
URGENCY

PAIN: LOCATION _____
RADIATION _____
ONSET _____
INTENSITY _____

YOUR PREVIOUS UROLOGICAL HISTORY / PROCEDURES

BLADDER _____
CYSTITIS _____
HEMATURIA _____
KIDNEY DISEASE _____
PROSTATE DISEASE _____
STONES _____
UROLOGICAL CANCERS _____
VASECTOMY _____

YOUR PRESENT MEDICAL HISTORY

CANCER (NON-URO) _____
CARDIAC _____
DIABETES _____
HIGH BLOOD PRESSURE _____
MITRAL VALVE PROLAPSE _____
PACEMAKER _____
PROSTHESIS _____
STROKE / MS / SPINAL INJURY _____
THYROID _____
OTHER _____

YOUR HOSPITALIZATIONS / OPERATIONS

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICATIONS YOU ARE TAKING

Medication	Dose	Frequency
1.		
2.		
3.		

YOUR ALLERGIES

1. _____
2. _____
3. _____
4. _____

DOCTOR'S NOTES

_____

_____

_____

_____

PLEASE COMPLETE THE REVERSE SIDE OF THIS SHEET

PATIENT HEALTH HISTORY FORM

PFSH

Marital Status:	M	S	W	D
Alcohol Use:	Never	Rarely	Moderate	Daily
Tobacco Use:	Y	N	Stopped	
Caffeine Use:	Y	N	How Much _____	
Excessive exposure at home or work to:		Fumes	Dust	Solvents

DO YOU HAVE A **FAMILY** HISTORY OF:

	NO	YES	WHO
1. Cancer (Location)	_____	_____	_____
2. Diabetes	_____	_____	_____
3. High Blood Pressure	_____	_____	_____
4. Heart Disease	_____	_____	_____
5. Stroke	_____	_____	_____
6. Thyroid Disease	_____	_____	_____
7. Urological	_____	_____	_____
8. Other	_____		

	Alive	Dead	Cause
1. Father	_____	_____	_____
2. Mother	_____	_____	_____
3. Brother/Sister	_____	_____	_____

REVIEW OF SYSTEMS

GENERAL

Appetite Change
Chills
Fever
Headache
Loss of Weight
_____
_____

E.N.T.

Ear Infection
Sore Throat
Sinus Problems
_____
_____

ENDOCRINE

Excessive Thirst
Too Cold
Too Hot
Tires/Sluggish
_____
_____

EYE

Blurred Vision
Double Vision
Pain
Ringing in Ears
_____
_____

GASTROINTESTINAL

Abdominal Pain
Appetite Poor
Constipation
Diarrhea
Liver Disease
Rectal Bleeding
_____
_____

SKIN

Bruise Easily
Hives
Itching
Rash
_____
_____

CARDIO / VASC

Chest pain
Phlebitis
Poor circulation
Swelling of ankles
Valve Disease
Varicose veins
_____
_____

MUSCLE, JOINT, & BONE

Arthritis
Back Pain
Joint Pain
Neck Pain
Osteoporosis
_____
_____

NEUROLOGICAL

Dizziness
Numbness
Parkinson's
Stroke
Tremors
_____
_____

RESPIRATORY

Asthma
Cough
Shortness of breathe
Tuberculosis
_____
_____

OTHER

Aids
Chemical Dependency
HIV Positive
_____
_____

NONE APPLY

REVIEWED_____**MD**

DATE:_____