WASHINGTON UROLOGY ASSOCIATES, PLLC & UROGYNECOLOGY

Patient History Form

Date: _____ Referring MD: _____ Primary Physician: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Marital Status: _____ Date of Birth: _____ Age: _____

PAST MEDICAL HISTORY (PLEASE CIRCLE): diabetes high blood pressure heart attack stroke hepatitis

cancer (specify) _____ kidney stone lung disease urinary infection kidney disease

Other:_____ _____ _____ _____

ALLERGIES (PLEASE CIRCLE): Penicillin Sulfa IVP dye Demerol Morphine

Betadine/Iodine Latex Tetracycline Codeine Cipro

Other:_____ _____ _____ _____

MEDICATIONS: ***List all current medications, vitamins and supplements**** **PAST SURGICAL HISTORY:** List all previous surgeries

MEDICINE	DOSE/HOW OFTEN	SURGERY	DATE	LOCATION

FAMILY HISTORY: Do any family members have/had (circle):

Cancer Yes No Who: _____ Diabetes Yes No Who: _____

If yes, specify: _____ Heart Disease Yes No Who: _____

Stroke Yes No Who: _____ Kidney Stones Yes No Who: _____

Kidney Disease Yes No Who: _____ Other: _____ Who: _____

Prostate Cancer Yes No Who: _____ Other: _____ Who: _____

SOCIAL HISTORY:

Occupation_____ Do you drink alcohol? No / Yes: How much? _____

Do you smoke? No / Yes: How much? _____ How long have you smoked? _____

Have you ever smoked? (circle one) No Yes If yes how much: _____Day When did you quit? _____

Do you have a decreased interest in sex which bothers you: Yes No

PLEASE TURN OVER & COMPLETE OTHER SIDE

REVIEW OF SYSTEMS:

Constitutional Symptoms

Fever	yes	no
Chills	yes	no
Headache	yes	no
Other_____		

Eyes

Blurred vision	yes	no
Double-vision	yes	no
Glaucoma	yes	no
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	yes	no
Sore throat	yes	no
Sinus problems	yes	no
Other _____		

Cardiovascular

Heart trouble	yes	no
Chest pain	yes	no
Ankle swelling	yes	no
High blood pressure	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

Genitourinary

Urinary retention	yes	no
Painful urination	yes	no
Urinary frequency	yes	no
Sexual concerns	yes	no
Loss of interest in sex	yes	no

Integumentary

Skin rash	yes	no
Boils	yes	no
Persistent itch	yes	no
Other_____		

Neurological

Tremors	yes	no
Dizzy spells	yes	no
Numbness/tingling	yes	no
Other _____		

Musculoskeletal

Joint pain	yes	no
Neck pain	yes	no
Back pain	yes	no
Other _____		

Endocrine

Excessive thirst	yes	no
Too hot/too cold	yes	no
Tired/sluggish	yes	no
Other_____		

Psychological

Are you generally satisfied with your life? yes no

Do you feel severely depressed? yes no

Have you considered suicide? yes no

Hematologic/Lymphatic

Bleeding problems	yes	no
Swollen glands	yes	no
Blood clotting	yes	no
Other _____		

Allergic/Immunologic

Hay fever	yes	no
Drug/food allergies	yes	no
Other _____		

If there is anything else you need to discuss with your doctor? _____

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Nurse use only: BP _____/_____ Pulse: _____Temp: _____ Weight: _____ Height: _____