THE UROLOGY INSTITUTE & CONTINENCE CENTER
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PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date _____ Date of Last Physical Exam _____
Last Name _____ First Name _____ Middle _____
Social Security # _____ Date of Birth _____ Last Menstrual Period _____

Chief Complaint

What is the main reason for your visit today? (Describe your problem in detail)

_____
_____

History of Present Illness

Please answer the following questions.

Location of the problem
Abdomen Back Leg
Other_____

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem.
1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other_____

Does anything help or make the problem worse?
Moving around Standing up Lying on my side
Other_____

How long does the problem last?
30 min. 1 hour It is always there
Other_____

Is there anything else occurring at the same time?
Yes No If yes, please explain.
Nausea Rash Headache
Other_____

Is the problem constant or variable?
Dull then sharp Very sharp then leaves Always there
Other_____

Does the problem interfere with your normal functions?
Yes No If yes, please explain
_____

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.)

_____ _____ _____
_____ _____ _____
_____ _____ _____

List any personal illnesses and/or surgeries and when they occurred.
Illness or surgery Date
_____
_____
_____

Do you smoke? Y N
If yes, how much?_____

Are you on any medications? Y N (If yes, list all)
_____ _____
_____ _____

Are you on a special diet? Y N (If yes, list all)
_____
_____

Do you drink? Y N
If yes, how much? _____

~Please turn over~

Review of Systems

Do you now or have you had any problems related to the following systems? Circle YES or NO.
Please explain any YES answers in the space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other _____

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N

Other _____

Allergic/ Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/tingling	Y	N

Other _____

Endocrine

Excessive Thirst	Y	N
Too hot/ cold	Y	N
Tired/ sluggish	Y	N

Other _____

Gastrointestinal

Abdominal Pain	Y	N
Nausea/ Vomiting	Y	N
Indigestion/ Heartburn	Y	N

Other _____

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N

Other _____

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistant Itch	Y	N

Other _____

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Other _____

Ear/ Nose/ Throat/ Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Other _____

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N

Other _____

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N

Other _____

Hematologic/ Lymphatic

Swollen Glands	Y	N
Blood Clotting	Y	N

Other _____

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other _____

Physician_____ **Date** _____