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**_____ **Age**____ **PSA**_____ **AUA Score**_____

CHIEF COMPLAINT

What is the main reason for your visit today? Please describe in detail.

_____

_____

_____

HISTORY OF PRESENT ILLNESS

Location of the problem. Please Circle

Abdomen Back R L Leg
Penis Testicles R L Rectum

How long does the problem last?

30 minutes 1 hour Constant
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

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

Does anything help or make the problem worse?

Moving around Standing Up Lying on Side
Other_____

Is the problem constant or variable?

Dull then sharp Very Sharp then leaves
Always There
Other_____

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago
Other_____

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

Physicians Use Only

Past Medical & Social History

List Any Personal Illnesses

_____
_____
_____
_____

List any Surgeries

_____
_____
_____
_____

Family History
Prostate Cancer Y N
Kidney Stones Y N

Do you smoke? Yes No
Have you ever smoked? Yes No
Do you drink? Yes No

Are you on a special diet? Yes No
Do you have any allergies to medications? Yes No. If yes, list.
_____

Are you on any medications? Yes No. If yes, please list below.

_____
_____
_____

REVIEW OF SYSTEMS

Please circle all symptoms that you have experienced since your last visit with our office:

CONSTITUTIONAL:	Fever	Chills	Weight Loss
EYES:	Blurry Vision	Double Vision	Cataracts
EARS, NOSE, MOUTH THROAT:	Hearing Loss	Nasal Stuffiness	Sore Throat
CARDIOVASCULAR:	Chest Pains	Swollen Ankles	Irregular Heartbeat
RESPIRATORY:	Shortness of Breath	Wheezing	Chronic Cough
GASTROINTESTINAL:	Abdominal Pain	Nausea/Vomiting	Change in Bowels
GENITOURINARY:	Incontinence	Painful Urination	Blood in Urine
MUSCULOSKELETAL:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles
INTEGUMENTARY/SKIN:	Rash	Persistent Itching	Skin Cancer History
NEUROLOGICAL:	Numbness	Tingling	Dizziness
HEMATOLOGIC:	Swollen Glands	Abnormal Bleeding	Transfusion History

NONE OF THE ABOVE