Longview Urology PLLC

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MEDICAL HISTORY FORM

Please Complete ALL Sections on this form, FRONT and BACK*

Patient's Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Chief Complaint: Briefly describe the reason for your visit to the Urologist today_____

_____

MEDICATIONS Please list ALL Medications, including Non-Prescription & Over-the-Counter medications (including Vitamins & Herbal Supplements) Be sure to list all **BLOOD THINNERS** [Aspirin, Anti-inflammatories, Coumadin/Warfarin, Plavix, etc.]

****Please feel free to bring a list for us to attach to your chart****

Medication & Strength	Medication & Strength
	___Blood thinners?

ALLERGIES Please list ALL Allergies to medications and include the type of reaction

Allergy & Reaction	Allergy & Reaction
	____ Latex Allergy? _____ Shellfish? _____ Iodine?

PAST MEDICAL HISTORY Please √ all medical problems you currently have and/or have had in the past

___ High Blood Pressure
___ High Cholesterol
___ Heart Attack
___ Congestive Heart Failure
___ Stroke
___ Heart Murmur
___ Diabetes
___ Bleeding Disorders
___ Anemia
___ Blood Clots
___ Asthma
___ COPD
___ Seizures
___ Thyroid Disease
___ Arthritis
___ Glaucoma
___ Depression
___ Bowel Problems
___ Parkinson's Disease
___ Gout
___ Hepatitis
___ Urinary Incontinence
___ Enlarged Prostate
___ Bladder Infections
___ Kidney Stones
___ Prostate Cancer
___ Breast Cancer
___ Other Cancer
Type:_____
___ Other:_____
___ Other:_____
___ Other:_____

PAST SURGICAL HISTORY Please √ and/or list all surgeries you have had in the past

Surgery & Date:	Surgery & Date:	Surgery & Date:
___ Tonsils	___ Bladder Surgery	___ Cataracts
___ Appendix	___ Prostate Surgery	___ Hernia
___ Gallbladder	___ Circumcision	___ Other:_____
___ Hysterectomy	___ Vasectomy	___ Other:_____
___ Kidney Surgery	___ Heart Bypass	___ Other:_____

FAMILY HISTORY Please √ all that apply to your relatives—parents, siblings, grandparents, children

___ High Blood Pressure
___ Strokes
___ Diabetes
___ Seizures
___ Psychiatric Disorders
___ Kidney Disease
___ Kidney Stones
___ Prostate Cancer
___ Bladder Cancer
___ Breast Cancer
___ Other Cancer
Type:_____

**********PLEASE CONTINUE ON OTHER SIDE********** → → → over → → →

SOCIAL HISTORY Please √ and answer all questions

Do you use tobacco? Never___ Presently___ Quit (& date)_____
How many packs per day do/did you smoke? _____
How many total years have you/did you smoke(d)? _____
Do you drink alcohol? _____drinks/week ____Social ____Never
Have you ever used recreational drugs? No___ Yes___
Occupation:_____ Retired? No___ Yes___

Please List your Daily Fluids (coffee/water/soda/alcohol, etc) and How much (cups/ounces): _____
_____
_____

What do you drink between dinner and bedtime, and how much?
_____

REVIEW OF SYSTEMS Please √ all that apply

Urinary Tract

____ Frequency of urination
Times per day____
___ Need to urinate at night
Times per night_____
___ Sudden, strong urge to urinate
___ Involuntary leakage of urine
Number of Pads per day _____
___ Urine leakage before getting to the toilet
___ Pain or burning with urination
___ Bladder pain or pressure
___ Blood in urine
___ Difficulty getting flow started
___ Slow, prolonged flow
___ Straining to urinate
___ Incomplete emptying of urine
___ Bladder Infections
How many per year?_____
___ Kidney Stones
Did you pass the stone?_____
Did you need surgery?_____

Constitutional

___ Weight gain / loss
___ Fever
___ Chills
___ Anorexia
___ Fatigue
___ Headaches

Eyes

___ Double Vision
___ Blurred Vision
___ Eye Pain

Ears, Nose, Throat

___Ear infection
___Sore Throat
___Sinus Problems
___Ringing in Ears

Cardiovascular

___Chest Pain / Angina
___High Blood Pressure
___Irregular Heart Beat
___Previous Heart Attack

Respiratory

___Shortness of Breath
___Wheezing
___Cough
___Asthma

Gastrointestinal

___Abdominal Pain
___Nausea
___Vomiting
___Constipation
___Diarrhea
___Heartburn / Indigestion
___Bowel Accidents

Musculoskelatal

___Back Pain
___Muscle Weakness
___Joint Pain / Stiffness

Skin

___Rashes
___Easy bruising
___Skin sores

Neurological

___Weakness
___Numbness
___Tingling
___Dizziness

Psychiatric

___Anxiety
___Depression
___Memory loss
___Alcohol / Drug addiction

Hematological/Lymphatic

___Enlarged lymph nodes
___Blood clotting problems
___Abnormal bruising

Male Issues

___Problems with erections
___No Interest in sex
___Ejaculation problems
___Painful erections
___Sore on genitals
___Discharge from penis
___Previous venereal disease
___Painful testicle
___Lump in testicle
___Foreskin problem
___Infertility Concern

Female Issues

Last PAP Smear_____
Last Menstrual Period_____
___Post-Menopausal
___Irregular Periods
___Painful Intercourse
___Vaginal Dryness
Could you be Pregnant?
Yes____ No____ Unsure____
How Many Children have you had?
Vaginal Deliveries____
C-Sections____
Miscarriages____

The Above Information is Correct.

Patient Signature: _____ **Date:**_____

NOTES: *(For Office Use Only)*

SCB/2009