UROLOGIC SPECIALTIES P.A.
PATIENT HISTORY FORM

DATE___/___/___**NAME**_____**DATE LAST PHYSICAL EXAM**____/____

CHIEF COMPLAINT {What is the main reason for your visit today? Describe your problem in detail }

_____

_____

_____

HISTORY OF PRESENT ILLNESS

Location of the problem {check or write in responses}
__ Abdomen ___Back___ Bladder ___ Genitals ___ Groin
__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?
1 2 3 Days ago 1 2 3 Weeks ago 1 2 3 Months ago

Other_____

How long does the problem last?
___30 minutes ___1 Hour ___ Always present

Other_____

Is anything else occurring at the same time? ___Y___N
___ Nausea/Vomiting ___ Fevers ___ Headaches ___ Rash

Other_____

Does anything help or make the problem worse?
___Moving Around ___ Standing Up ___ Lying Down

Other_____

Does the problem interfere with your normal function? ___Y___N

_____

Physician Use Only: {comments/notes}

_____

_____

PAST MEDICAL & SOCIAL HISTORY

List any past illnesses and/or surgeries and when they occurred

Illness or Surgery	Date
	/ /
	/ /
	/ /
	/ /

List all serious illness in your immediate family.
{Diabetes, Heart Disease, Cancer, Bleeding Disorders, etc}

_____

_____

_____

Do you Smoke? ___Y ___ N If yes how much?_____

Do you drink? ___Y ___ N If yes, how much?_____

Do you have any allergies? ___Y ___N (If yes, please explain)

_____

Are you on any medication? ___Y ___N (If yes, please list)

_____ _____

_____ _____

_____ _____

Do take aspirin or coumadin? ___Y ___ N

PLEASE COMPLETE REVIEW OF SYSTEMS QUESTIONAIRE

Physician Use Only: {comments/notes}