

# ADVANCED UROLOGY OF SOUTH FLORIDA

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## PATIENT HISTORY FORM

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Primary Dr.: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_  Male  Female

### Chief Complaint

What is the main reason for your visit? \_\_\_\_\_

When did you notice the problem? \_\_\_\_\_

How long does the problem last? \_\_\_\_\_

Where is the problem located? \_\_\_\_\_

What makes it better or worse? \_\_\_\_\_

How severe is the problem on a 0 to 10 scale? (Least Severe) 0 1 2 3 4 5 6 7 8 9 10 (Most Severe)

Does it interfere with normal functions? \_\_\_\_\_

### Past Medical History and Social History

Marital Status  Single  Married  Divorced  Widow

Race  Caucasian  African-American  Hispanic  Other \_\_\_\_\_

Education  High School/GED  College  Graduate Degree  Other \_\_\_\_\_

Occupation \_\_\_\_\_  Part-Time  Full-Time

Use of Tobacco  Yes  No Former If yes, how many packs? Per Day \_\_\_\_\_ Per Week \_\_\_\_\_

Use of Alcohol  Yes  No Former If yes, how many drinks? Per Day \_\_\_\_\_ Per Week \_\_\_\_\_

Do you take antibiotics prior to dental work or other procedures?  Yes  No

If yes, Why? \_\_\_\_\_

Have you needed chemotherapy or radiation?  Yes  No

If yes, Why? \_\_\_\_\_

Are you taking any blood thinners?  Yes  No  Aspirin  Coumadin  Other \_\_\_\_\_

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## List Any Surgeries/Including Dates:

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## List Any Medical Illness / Including Dates:

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### Family History

History of Prostate Cancer?  Yes  No If yes, Who? \_\_\_\_\_

Father  Alive  Deceased at Age \_\_\_\_\_ Medical  
Problems? \_\_\_\_\_

Mother  Alive  Deceased at Age \_\_\_\_\_ Medical  
Problems? \_\_\_\_\_

Siblings Medical Problems: \_\_\_\_\_

Children Medical Problems: \_\_\_\_\_

## Remarks:

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## Review of Systems

Who is your family physician? \_\_\_\_\_

If applicable, who is your cardiologist? \_\_\_\_\_

Do you now, or have you had problems related to the following:

### General:

Fever  Yes  No  
Chills  Yes  No  
Weight Loss  Yes  No  
Other: \_\_\_\_\_

### Integumentary:

Skin Rash  Yes  No  
Persistent Itch  Yes  No  
Other: \_\_\_\_\_

### Eyes:

Vision Difficulties  Yes  No  
Glaucoma  Yes  No  
Other: \_\_\_\_\_

### Musculoskeletal:

Arthritis  Yes  No  
Back Pain  Yes  No  
Other: \_\_\_\_\_

### Allergic:

Penicillin  Yes  No  
Sulfa  Yes  No  
IV Contrast  Yes  No  
Other: \_\_\_\_\_

### Ear/Nose/Throat:

Dry Mouth  Yes  No  
Sinus Problem  Yes  No  
Other: \_\_\_\_\_

### Neurological:

Dizzy Spells  Yes  No  
Strokes (CVA)  Yes  No  
Tremors  Yes  No  
Other: \_\_\_\_\_

### Respiratory:

Emphysema (COPD)  Yes  No  
Shortness of Breath  Yes  No  
Wheezes  Yes  No  
Other: \_\_\_\_\_

### Endocrine:

Diabetes  Yes  No  
Thyroid Disease  Yes  No  
Excess Thirst  Yes  No  
Heat / Cold Intolerance  Yes  No  
Other: \_\_\_\_\_

### Hematological/Lymphatic:

Immune Disorder  Yes  No  
Blood Clotting Problem  Yes  No  
Other: \_\_\_\_\_

### Gastrointestinal:

Nausea / Vomiting  Yes  No  
Ulcers / Heartburn  Yes  No  
Hepatitis  Yes  No  
Other: \_\_\_\_\_

### Urological/Renal:

Erectile Dysfunction (men)  Yes  No  
Urinary Infections  Yes  No  
Kidney Disease/or Failure  Yes  No  
Kidney Stones  Yes  No  
Other: \_\_\_\_\_

### Cardiovascular:

Chest Pain / Angina  Yes  No  
Heart Attack  Yes  No  
High Blood Pressure  Yes  No  
Heart Murmur  Yes  No  
Other: \_\_\_\_\_

### Psychological:

Depression  Yes  No  
Anxiety  Yes  No  
Other: \_\_\_\_\_