## Urology Associates Medical Group, P.C.

### Medical History Form

Name:_______________ Age:__________ Date of Birth:__________

Referring Physician:______________________________

Family Physician:______________________________

Pharmacy:______________ Phone:______________________

Your Occupation:____________________ Retired? Yes No

This information is now required by the Federal Government
Primary Language______________ Race__________ Ethnicity__________

**CHIEF COMPLAINT**
What is the main reason for your visit today to the Urologist?________________

______________________________________________

**List all of your current prescribed and over the counter medications:**

Drug Name & Dose________________ Drug Name & Dose____________

Drug Name & Dose________________ Drug Name & Dose____________

Drug Name & Dose________________ Drug Name & Dose____________

Are you ALLERGIC to any medications? YES NO
If yes, Please list the medications you are allergic to:____________________

______________________________________________

**LIST ALL SURGERIES/DATES**

Surgery:____________________ Date:________________

Surgery:____________________ Date:________________

Surgery:____________________ Date:________________

**Medical History (Circle the appropriate response in each column)**

| Do you have a history of: | | |
|---|---|---|
| Diabetes | YES | NO |
| Heart Disease | YES | NO |
| Cancer | YES | NO |
| High Blood Pressure | YES | NO |
| Kidney Stones | YES | NO |
| Stroke | YES | NO |
| Bleeding Disorder | YES | NO |
| Breathing Problem | YES | NO |

Other Medical History:__________________________
________________________________________________

| Does your family have a history of: | | | Relationship to patient |
|---|---|---|---|
| Diabetes | YES | NO | ____________________ |
| Heart Disease | YES | NO | ____________________ |
| Prostate Cancer | YES | NO | ____________________ |
| Bladder Cancer | YES | NO | ____________________ |
| Kidney Cancer | YES | NO | ____________________ |
| Father Living | YES | NO | |
| Mother Living | YES | NO | |

Cause of Death (Father)________________________________________
Cause of Death (Mother)________________________________________

**Marital Status**: (Circle) Married Single Widowed
Number of children?____________

How many caffeine drinks do you consume daily?____________________________________________

**Have you ever smoked?** YES NO
If yes, how long have you smoked?____________________________________________________________
If yes, how long ago did you quit?______________________________________________________________

**Do you drink alcohol?** YES NO
If yes, do you drink: Daily Weekly Social

**REVIEW OF BODY SYSTEMS**
Please identify if you currently have problems related to the following systems:

**Constitutional Symptoms:**

| | | |
|---|---|---|
| Fever | YES | NO |
| Chills | YES | NO |

**Hematologic/Lymphatic Symptoms:**

| | | |
|---|---|---|
| Swollen Glands: | YES | NO |
| Blood Clotting | YES | NO |

**Gastrointestinal Symptoms:**

| | | |
|---|---|---|
| Abdominal Pain | YES | NO |
| Nausea/Vomiting | YES | NO |
| Indigestion | YES | NO |

**Genitourinary Symptoms:**

| | | |
|---|---|---|
| Urine Retention | YES | NO |
| Painful Urination | YES | NO |
| Visible Blood in Urine | YES | NO |
| Urinary Frequency | YES | NO |
| Urinary Leakage | YES | NO |

**Cardiovascular Symptoms:**

| | | |
|---|---|---|
| Chest Pain | YES | NO |
| Hypertension | YES | NO |
| Heart Attack | YES | NO |
| High Cholesterol | YES | NO |
| Pacemaker or Valve | YES | NO |

**Neurological Symptoms:**

| | | |
|---|---|---|
| Tremors | YES | NO |
| Difficulty Walking | YES | NO |
| History of Seizure Disorder | YES | NO |

**Integumentary Symptoms:**

| | | |
|---|---|---|
| Unexplained Weight Loss | YES | NO |
| Excessive Thirst | YES | NO |

**Musculoskeletal Symptoms:**

| | | |
|---|---|---|
| Joint Pain | YES | NO |
| Neck Pain | YES | NO |

| | | | | | |
|---|---|---|---|---|---|
| Hot/Cold Spells | YES | NO | Back Pain | YES | NO |

| **Respiratory Symptoms:** | | | **Psychological:** | | |
|---|---|---|---|---|---|
| Wheezing | YES | NO | Do you have anxiety? | YES | NO |
| Frequent Cough | YES | NO | Are you depressed? | YES | NO |
| Shortness of Breath | YES | NO | | | |

Number of Pregnancies:___________________________

Current PSA:________________________

Date drawn:_________________________

Is there any additional information that you feel your physician should know?______________

_____________________________________________________________________________________