Patient History Form (Please Print) Date:_____

Last Name:_____First Name: __ _____MI_____

Social Security No:_____Date of Birth ____/____/____ Height_____Weight_____

What is the main reason for your visit? (Describe your problem in detail)

_____
_____
_____

Allergies and Medications

List your current <u>ALLERGIES</u>:

_____
_____

List all your current <u>MEDICATIONS AND DOSES</u>: (you may provide a list if available)

_____
_____
_____
_____

Provide the <u>NAME</u>, <u>ADDRESS</u> and <u>PHONE NUMBERS</u> of your preferred <u>PHARMACIES</u>.

_____
_____

Past Medical History

List any personal illnesses/diagnosis/disease and when they occurred: Example (Bladder cancer, Diabetes)

_____
_____
_____
_____

Past Surgical History

List any procedures/surgeries you have had. Please provide approximate date of procedure/surgery:

_____
_____

Family History

Circle any illnesses in your immediate family: Include the relationship to you :

Prostate Problems _____ Bladder Cancer_____ Kidney Cancer_____ Breast Cancer_____
Diabetes_____ Heart Problems _____ High Blood Pressure _____Uterine Cancer _____
Kidney Failure _____ Infertility _____ Lung Cancer_____ Skin Cancer_____ Tuberculosis _____
Parkinson's Disease_____ Kidney Stones _____ Thyroid Problems _____ Stroke _____

Obstetric and Gynecological History (Females Only)

Number of Pregnancies _____ Number of Deliveries_____ Number C Section_____ Number Vaginal Delivery____ Age at Menopause (if applicable)_____

Social History (Circle answer)

Marital Status: Married Single Divorced Widowed Separated Unknown

Smoking Status: Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoker Smoker/status unknown Unknown

If ever Smoked answer the following:

How much do you/did you smoke? _____ For how many years did/have you smoked? _____

Do you Drink Alcohol? Yes Not Any More Never Drank

Type(s) of alcohol consumed: Beer Wine Alcohol Drinking Habit: Social Light Moderate Excessive

How many caffeinated drinks to you have each day? 0 1 2 3 4+ Have you had a blood transfusion? Yes No

Language English Spanish French German Portuguese Russian Chinese Japanese Italian Other

Race White Black/ African American American Indian/Alaska Native Eskimo Hispanic Asian Pacific Islander Unknown

Review of Systems (Circle all that apply)

Constitutional: **Fever** Chills Weight loss Other:_____

Eyes: Blurry Vision Double Vision Cataracts Other: _____

Ears, Nose Mouth and throat: Hearing Loss Nasal Stuffiness Sore Throat Other:_____

Cardiovascular : Chest Pain Swollen Ankles Irregular Heartbeat Other:_____

Respiratory: Shortness of Breath Wheezing Chronic Cough Other:_____

Gastrointestinal: Abdominal Pain Nausea/Vomiting Change in Bowels Other: _____

Genitourinary: Incontinence Painful Urination Blood in Urine Other: _____

Musculoskeletal : Chronic back pain Chronic neck pain Sore Muscles Other: _____

Integumentary/Skin : Rash Persistent Itching Skin Cancer History Other: _____

Neurological: Numbness Tingling Dizziness Other: _____

Hematologic/Lymphatic: Swollen Glands Abnormal Bleeding Transfusion History Other: _____

AUA Symptom Score (Males Only)

Questions to be answered	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost Always
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Over the past month, how often have you had to urinate less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. On a nightly basis, how many times do you typically get up to urinate?	0	1	2	3	4	5

Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Sum the seven circled numbers (AUA Symptom Score): _____ Scoring: Mild 0-7 Moderate: 8-19 Severe 20-35

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