



Urological Consultants OF FLORIDA

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

LAST NAME _____ FIRST NAME: _____ DOB: _____ DATE: _____

Why are you consulting a Urologist? _____

Medical History

Medical None (*High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.*)

Females: How many pregnancies _____ How many children _____ **Males:** Last prostate and/or rectal exam _____

Surgery None (*Type and Year*)

Allergies to medications? None (*If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.*)

Current prescription medicines None

Name of drug mg dose # tablets # times per day

Current prescription medicines

Name of drug mg dose # tablets # times per day

OTC medicines. (*Aspirin, Tylenol, Ibuprofen, Aleve, vitamins and herbals.*)

Family History

	Living	Deceased	Illness	Cause of Death/Age
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister (s)	<input type="checkbox"/> # _____	<input type="checkbox"/> # _____	_____	_____
Brother (s)	<input type="checkbox"/> # _____	<input type="checkbox"/> # _____	_____	_____

Family History of:	Yes	No	Family Member	Yes	No	Family Member
1. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Lung/pulmonary disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History

Do you smoke? Yes No For how many years? _____ How many per day? _____
 Have you ever smoked? Yes No For how many years? _____ How many per day? _____
 When did you stop? _____

Do you routinely exercise? Yes No

Caffeine consumption: Coffee: Cups per day: _____ Tea: Cups per day: _____
 Other: _____

Alcohol consumption: Type: _____ Amount: _____ Per _____
 Type: _____ Amount: _____ Per _____

Dietary restrictions: _____

Review of Systems

Circle Yes or No.

Constitutional Symptoms	(Comments)	Genitourinary	(Comments)
Weight change	Y N	Change in stream	Y N
Chills	Y N	Nocturia (getting up at night)	Y N
Fever	Y N	Urinary frequency > 8 times/day	Y N
Other		Burning with urination	Y N
		Other:	
Eyes		Musculoskeletal	
Glaucoma	Y N	Muscle weakness	Y N
Cataracts	Y N	Joint pain (swelling)	Y N
Other		Other	
Cardiovascular		Neurological	
Chest pain	Y N	Tremors	Y N
Irregular heartbeat	Y N	Dizzy spells	Y N
Swelling in ankles	Y N	Numbness/tingling	Y N
Other		Stroke	Y N
Psychologic		Respiratory	
Do you feel depressed?	Y N	Wheezing	Y N
Do you feel anxious?	Y N	Frequent cough	Y N
		Shortness of breath	Y N
		Other	
Endocrine		Gastrointestinal	
Excessive thirst	Y N	Abdominal pain	Y N
Too hot/cold	Y N	Nausea/vomiting	Y N
Other		Indigestion/heartburn	Y N
		Constipation/Diarrhea	Y N
Hematologic/Lymphatic		Sexual History	
Swollen glands	Y N	Change in sex drive?	Y N
Blood clotting problem	Y N	Sexual performance satisfactory?	Y N
Bruising	Y N	Other	
Other			

MALE ONLY

AUA Symptom Score: Circle one number on each line

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	<i>Delighted</i>	<i>Pleased</i>	<i>Mostly Satisfied</i>	<i>Mixed</i>	<i>Mostly Dissatisfied</i>	<i>Unhappy</i>	<i>Terrible</i>
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 to 19 Severe: 20 – 35							

Physician Signature: _____

Date _____