# 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 ALLERGIES:**

_______________________________________________________________________________________________
_______________________________________________________________________________________________

**List all your current MEDICATIONS AND DOSES: (you may provide a list if available)**

_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

**Provide the NAME, ADDRESS and PHONE NUMBERS of your preferred PHARMACIES.**

_______________________________________________________________________________________________
_______________________________________________________________________________________________

## 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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