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

North Miami Office: 12411 Biscayne Boulevard North Miami FL 33181 Tel: 305 672 4222Fax: 305 672 5461