PENINSULA UROLOGY ASSOCIATES, P.A.

Patient History Form

Name: _____ Date: _____
SS# _____ Age: _____ Sex: Male ___ Female ___
Primary physician: _____ Is this who referred you to us? Yes __ No __
If no, then who? _____ Other physicians: _____

Reason for coming to this office: _____
_____
_____

Have you ever seen a urologist before? Yes __ No __ If so, who? _____
Have you ever had any of the following?

	Yes	No		Yes	No
Asthma	___	___	Hepatitis	___	___
Emphysema/COPD	___	___	Hypertension	___	___
Heart disease	___	___	Tuberculosis	___	___
Diabetes	___	___	HIV	___	___
Cancer	___	___	Venereal disease	___	___
If so, what type? _____			Glaucoma	___	___
_____			Parkinson's disease	___	___
Any other medical illnesses?			Multiple Sclerosis	___	___

_____
_____

List prior operations and approximate dates:

_____ _____
_____ _____
_____ _____

List all medication and doses (including over the counter and herbal drugs, etc)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you take any of the following on a regular basis?

	Yes	No		Yes	No
Coumadin	___	___	Ibuprofen/NSAIDS	___	___
Plavix	___	___	Vitamin E	___	___
Aspirin	___	___	Nitrates	___	___

Are you allergic to any medications?
If yes, please list: _____

Have you ever had an allergic reaction to contrast dye? Yes __ No __

PLEASE FLIP OVER SHEET **---------->**

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Social History

Do you smoke? Yes ___ No ___ If yes, amount: _____

Previously smoked? Yes ___ No ___ If yes, amount: _____

Do you drink alcohol? Yes ___ No ___ If yes, amount: _____

Marital status: Single ___ Married ___ Divorced ___ Widowed ___

Occupation: _____ Highest level of education: _____

Family History

Has anyone in your family had any kidney, bladder or prostate problems? Yes ___ No ___

If yes, what? _____

Review of systems

Have you had any recent problems with the following?

Constitutional	Yes	No
Fatigue	___	___
Night Sweats	___	___
Unexplained weight loss	___	___
HEENT		
Change in vision	___	___
Change in hearing	___	___
Sore Throat	___	___
Neurological		
Dizzy Spells	___	___
Headache	___	___
Numbness/Tingling	___	___
Stroke	___	___
Gastrointestinal		
Abdominal pain	___	___
Blood in stool	___	___
Change in bowel habits	___	___
Nausea/vomiting	___	___
Rectal Bleeding	___	___
Cardiovascular/Respiratory		
Blood in sputum	___	___
Chest, Arm pain with exertion	___	___
Frequent coughing	___	___
High Blood Pressure	___	___
Shortness of breath	___	___

Musculoskeletal	Yes	No
Arthritis	___	___
Back pain	___	___
Joint pain	___	___
Muscle weakness	___	___
Genitourinary		
Blood in urine	___	___
Burning on urination	___	___
Erection problems	___	___
Kidney stones	___	___
Urinary frequency	___	___
Urinary hesitancy	___	___
Urinary tract infections	___	___
Hematologic		
Bleeding problem	___	___
Swollen Glands	___	___
Psychiatric		
Anxiety	___	___
Depression	___	___
Skin		
Skin Rashes	___	___
Endocrine		
Excess Thirst or Hunger	___	___
Intolerance to Heat or Cold	___	___