Longview Urology PLLC

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MEDICAL HISTORY FORM

Please Complete ALL Sections on this form, FRONT and BACK

Patient's Name:________________________ **Date of Birth:**______________ **Today's Date:**_____________

Chief Complaint: Briefly describe the reason for your visit to the Urologist today____

____

MEDICATIONS Please list ALL Medications, including Non-Prescription & Over-the-Counter medications (including Vitamins & Herbal Supplements)
Be sure to list all **BLOOD THINNERS** [Aspirin, Anti-inflammatories, Coumadin/Warfarin, Plavix, etc.]
Please feel free to bring a list for us to attach to your chart

Medication & Strength	Medication & Strength
	___Blood thinners?

ALLERGIES Please list ALL Allergies to medications and include the type of reaction

Allergy & Reaction	Allergy & Reaction
	____ Latex Allergy? _____ Shellfish? _____ Iodine?

PAST MEDICAL HISTORY Please √ all medical problems you currently have and/or have had in the past

___ High Blood Pressure
___ High Cholesterol
___ Heart Attack
___ Congestive Heart Failure
___ Stroke
___ Heart Murmur
___ Diabetes
___ Bleeding Disorders
___ Anemia
___ Blood Clots
___ Asthma
___ COPD
___ Seizures
___ Thyroid Disease
___ Arthritis
___ Glaucoma
___ Depression
___ Bowel Problems
___ Parkinson's Disease
___ Gout
___ Hepatitis
___ Urinary Incontinence
___ Enlarged Prostate
___ Bladder Infections
___ Kidney Stones
___ Prostate Cancer
___ Breast Cancer
___ Other Cancer
Type:___________________
___ Other:_____________
___ Other:_____________
___ Other:_____________

PAST SURGICAL HISTORY Please √ and/or list all surgeries you have had in the past

Surgery & Date:	Surgery & Date:	Surgery & Date:
___ Tonsils	___ Bladder Surgery	___ Cataracts
___ Appendix	___ Prostate Surgery	___ Hernia
___ Gallbladder	___ Circumcision	___ Other:_________________
___ Hysterectomy	___ Vasectomy	___ Other:_________________
___ Kidney Surgery	___ Heart Bypass	___ Other:_________________

FAMILY HISTORY Please √ all that apply to your relatives—parents, siblings, grandparents, children

___ High Blood Pressure
___ Strokes
___ Diabetes
___ Seizures
___ Psychiatric Disorders
___ Kidney Disease
___ Kidney Stones
___ Prostate Cancer
___ Bladder Cancer
___ Breast Cancer
___ Other Cancer
Type:_________________

**********PLEASE CONTINUE ON OTHER SIDE********** → → → over → → →

SOCIAL HISTORY Please √ and answer all questions

Do you use tobacco? Never___ Presently___ Quit (& date)_____
How many packs per day do/did you smoke? ______
How many total years have you/did you smoke(d)? ______
Do you drink alcohol? ______drinks/week ____Social ____Never
Have you ever used recreational drugs? No___ Yes___
Occupation:________________________ Retired? No___ Yes___

Please List your Daily Fluids (coffee/water/soda/alcohol, etc) and How much (cups/ounces): ______________________________

What do you drink between dinner and bedtime, and how much? ______________________________

REVIEW OF SYSTEMS Please √ all that apply

Urinary Tract

___ Frequency of urination
Times per day____
___ Need to urinate at night
Times per night_____
___ Sudden, strong urge to urinate
___ Involuntary leakage of urine
Number of Pads per day _____

___ Urine leakage before getting to the toilet
___ Pain or burning with urination
___ Bladder pain or pressure
___ Blood in urine
___ Difficulty getting flow started
___ Slow, prolonged flow
___ Straining to urinate

___ Incomplete emptying of urine
___ Bladder Infections
How many per year?_____
___ Kidney Stones
Did you pass the stone?_____
Did you need surgery?______

Constitutional
___ Weight gain / loss
___ Fever
___ Chills
___ Anorexia
___ Fatigue
___ Headaches

Eyes
___ Double Vision
___ Blurred Vision
___ Eye Pain

Ears, Nose, Throat
___Ear infection
___Sore Throat
___Sinus Problems
___Ringing in Ears

Cardiovascular
___Chest Pain / Angina
___High Blood Pressure
___Irregular Heart Beat
___Previous Heart Attack

Respiratory
___Shortness of Breath
___Wheezing
___Cough
___Asthma

Gastrointestinal
___Abdominal Pain
___Nausea
___Vomiting
___Constipation
___Diarrhea
___Heartburn / Indigestion
___Bowel Accidents

Musculoskeletal
___Back Pain
___Muscle Weakness
___Joint Pain / Stiffness

Skin
___Rashes
___Easy bruising
___Skin sores

Neurological
___Weakness
___Numbness
___Tingling
___Dizziness

Psychiatric
___Anxiety
___Depression
___Memory loss
___Alcohol / Drug addiction

Hematological/Lymphatic
___Enlarged lymph nodes
___Blood clotting problems
___Abnormal bruising

Male Issues
___Problems with erections
___No Interest in sex
___Ejaculation problems
___Painful erections
___Sore on genitals
___Discharge from penis
___Previous venereal disease
___Painful testicle
___Lump in testicle
___Foreskin problem
___Infertility Concern

Female Issues
Last PAP Smear_________
Last Menstrual Period________
___Post-Menopausal
___Irregular Periods
___Painful Intercourse
___Vaginal Dryness
Could you be Pregnant?
Yes____ No____ Unsure____
How Many Children have you had?
Vaginal Deliveries____
C-Sections____
Miscarriages____

The Above Information is Correct.

Patient Signature: ________________________________ **Date**:________________

NOTES: (For Office Use Only)