UROLOGY ASSOCIATES OF MOBILE, P.A

MEDICAL HISTORY FORM PATIENT_____

DATE_____ DATE OF BIRTH_____

PROBLEMS: STATE REASONS YOU WANT TO SEE A DOCTOR. LIST IN ORDER OF IMPORTANCE TO YOU. YOU MAY WANT TO USE THE BACK OF THE PAGE TO DESCRIBE IN DETAIL IF YOU WISH.

1._____

2._____

NAME OF PHYSICIAN OR PERSON (FIRST AND LAST NAME) SENDING YOU TO US:

_____

LIST PHYSICIANS (FIRST AND LAST NAMES) SEEN IN LAST TWO YEARS AND WHY:

_____

MEDICAL HISTORY:

ILLNESSES_____

ACCIDENTS_____

OPERATIONS_____

FAMILY HISTORY – DOES ANYONE IN YOUR FAMILY HAVE CANCER OF:

PROSTATE	YES	NO
KIDNEY	YES	NO
BLADDER	YES	NO

SOCIAL HISTORY:

OCCUPATION: _____

SMOKE TOBACCO	YES	NO
DRINK ALCOHOL	YES	NO

ALLERGIES: LIST ANY MEDICATIONS (INCLUDING X-RAY DYE) THAT YOU HAVE HAD A REACTION TO: _____

_____

_____

MEDICATIONS: LIST ALL MEDICATIONS YOU ARE NOW TAKING (INCLUDING ASPIRIN) AND LIST HOW OFTEN YOU TAKE THEM: _____

_____

_____

_____

_____

PREFERRED PHARMACYAND LOCATION: _____

REVIEW OF SYSTEMS

CONSTITUTIONAL

Fever	Yes	No
Fatigue	Yes	No
Weight Loss	Yes	No

EYES

Blurred Vision	Yes	No
Double Vision	Yes	No

EAR/NOSE/THROAT/MOUTH

Sore Throat	Yes	No
Nasal Congestion	Yes	No
Sinus Pain	Yes	No
Postnasal Drip	Yes	No

CARDIOVASCULAR

Chest Pain	Yes	No
Heart Murmur	Yes	No
Irregular Heartbeat	Yes	No
Swelling of Legs	Yes	No

RESPIRATORY

Wheezing	Yes	No
Cough	Yes	No
Shortness of Breath		
With Exertion	Yes	No
With Rest	Yes	No

GASTROINTESTINAL

Nausea/Vomiting	Yes	No
Change in Bowel Habits	Yes	No
Black/Bloody Stool	Yes	No
Constipation	Yes	No

PATIENT NAME _____

DATE OF BIRTH _____

TODAY'S DATE _____

GENITOURINARY

Difficulty Voiding	Yes	No
Incomplete Emptying	Yes	No
Urine Stops and Starts	Yes	No
Weak or Slow Stream	Yes	No
Are your symptoms severe enough to take Medication	Yes	No
Painful Urination	Yes	No
Voiding too Frequently	Yes	No
Have to Void in a Hurry	Yes	No
Leak Urine when		
Coughing or Sneezing	Yes	No
Bathroom not Nearby	Yes	No
Up to Urinate at Night More than Twice	Yes	No
If Yes, Number of Times	2 3 4 More	
Does this bother you	Yes	No
Blood or Pus in Urine	Yes	No

SKIN

Rash	Yes	No
Persistent Itching	Yes	No

NEUROLOGICAL

Headaches	Yes	No
Seizures	Yes	No
Paralysis	Yes	No

MUSCULOSKELETAL

Back Pain	Yes	No
Joint Pain	Yes	No
Neck Pain	Yes	No
Extremity Pain	Yes	No

SEXUAL

Male:

Problem with Erections	Yes	No
Problems with Ejaculation	Yes	No
Problem with Sexual Drive	Yes	No

Female:

Problem with Intercourse	Yes	No
Problem with Climax	Yes	No
Problem with Sexual Drive	Yes	No

MEDICATION LIST

PLEASE INCLUDE ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS

PATIENT: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____