Health History

Patient Name: ______________ Date of Birth: ________________ Today's Date: ______________

What issues bring you here today? List in order of importance to you.

1. ____
2. ____
3. ____

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:

☐ *No Pertinent History* ☐ Asthma ☐ Bladder Cancer ☐ BPH ☐ Congestive Heart Failure
☐ COPD ☐ Coronary Artery Disease ☐ Diabetes Type I
☐ Diabetes Type II ☐ Erectile Dysfunction ☐ Reflux
☐ Gout ☐ High Cholesterol ☐ High Blood Pressure
☐ Hypogonadism ☐ Hypothyroidism ☐ Infertility
☐ Kidney Stones ☐ Prostate Cancer ☐ Kidney Cancer

Other: ____

Surgical History:

☐ *No Pertinent History* ☐ Appendix Removal ☐ Back Surgery ☐ Gallbladder Removal
☐ Colonoscopy ☐ Hernia Surgery ☐ Hysterectomy ☐ Vasectomy

Other: ____

Medications: List all medications you are taking (including Aspirin) and frequency of each:

____
____
____
____

Allergies: List any medications (including x-ray dye) that you have had a reaction to:

☐ None ☐ Contrast Dye Other: ______________________________

Family History:

☐ *No Pertinent History* ☐ Bladder Cancer ☐ Diabetes ☐ Heart Disease
☐ High Blood Pressure ☐ Prostate Cancer ☐ Kidney Cancer

Other: ____

Social History:

Tobacco: ☐ Never ☐ Former ☐ Current Some Days ☐ Current Every Day
Alcohol: ☐ Never ☐ Former ☐ Current Some Days ☐ Current Every Day

Review of Systems

Patient Name: ____________ Date of Birth: ______________ Today's Date: _____________

Preferred Pharmacy Name & Number: ______________________________

Please select the below genitourinary symptoms you are currently experiencing:

Storage Symptoms:

☐ Voiding too Frequently ☐ Up to Urinate at Night More than Twice

☐ Have to Void in a Hurry ☐ Leak Urine when Bathroom Not Nearby

Voiding Symptoms:

☐ Hard to Start Urination ☐ Slow Stream ☐ Straining to Void ☐ Urine Stops & Starts

☐ Do Not Feel Empty ☐ Dribbling Post Void

Sexual Function Symptoms:

☐ Low Sex Drive ☐ Problem Obtaining Erection ☐ Problem Maintaing Erections ☐ Premature Ejaculation

Other Symptoms:

☐ Pain with Urination ☐ Blood or Pus in Urine ☐ Leak Urine when Sneezing/Coughing

Please select symptoms below that you are CURRENTLY experiencing.

CONSTITUTIONAL: ☐ Weight Loss

EAR/NOSE/THROAT/MOUNT: ☐ Sore Throat

CARDIOVASCULAR: ☐ Chest Pain

RESPIRATORY: ☐ Coughing Blood

GASTROINTESTINAL: ☐ Bloody Stool

SKIN: ☐ Changes to Existing Moles or Lesions

NEUROLOGICAL: ☐ Seizures

MUSCULOSKELETAL: ☐ Limitation of Motion in Upper Extremities

ENDOCRINE: ☐ Excessive Thirst

HEME-LYMPH: ☐ Easy Bruising

Do you have a Living Will: ☐ Yes ☐ No If yes, please include name: ____________________