Bellevue Urology Patient History Form

Date:_____________ Referring MD:______________________________ Primary Physician:____________________

Last Name:___________________________ First Name:_______________________________ Middle Initial:________

Social Security #:__________________________________ Date of Birth:___________________ Age:_____________

HAVE YOU EVER HAD:

Urinary infection?----------------------------------	yes	no
Kidney stones?-------------------------------------	yes	no
Prostate disorder?----------------------------------	yes	no
Surgery on kidneys, bladder,genital organs?-----	yes	no
Blood, pus, protein, sugar in urine?---------------	yes	no
Venereal disease?-----------------------------------	yes	no
Previous x-ray/ultrasound/CT scan of kidneys?--	yes	no

MEDICATIONS:

List current medicines (including aspirin if applicable)

MEDICINE	DOSE

PAST SURGICAL HISTORY:

list previous surgeries

SURGERY	DATE	WHERE (overlake?)

ALLERGIES:

circle those applicable - penicillin, SULFA, IVP dye

Demerol, morphine, codeine, betadine/iodine, latex,

Tetracycline, other____________________________

PAST MEDICAL HISTORY:

circle those applicable - diabetes, high blood pressure, heart attack,

stroke, kidney disease, urinary infection, cancer, lung disease,

hepatitis, other____

FAMILY HISTORY:

Does anyone in your family have:

father:

alive? _____ age @ death? _____

cause of death? _______________

mother:

alive? _____ age @ death? _____

cause of death? _______________

Cancer?	Yes_______	who?____________________________
Diabetes?	Yes_______	who?____________________________
Heart disease?	Yes________	who?____________________________
Stroke?	Yes________	who?____________________________
High blood pressure?	Yes________	who?____________________________
Kidney disease/stones?	Yes________	who?____________________________
other? ___________________________		who?____________________________

PLEASE TURN OVER & COMPLETE OTHER SIDE

SOCIAL HISTORY:

1) Occupation ____

2) Do you drink alcohol? no____ occasionally____ 1 – 2 drinks/day____ 3 or more drinks/day____

3) Do you smoke? no____ yes____ # packs/day____ for how long?____ (former smoker, quit since______)

4) Any previous drug or alcohol dependence? no____ yes____

REVIEW OF SYSTEMS:

Constitutional Symptoms

fever	yes	no
chills	yes	no
headache	yes	no
other _____________________		

Eyes

blurred vision	yes	no
double vision	yes	no
glaucoma	yes	no
other______________________		

Neurological

tremors	yes	no
dizzy spells	yes	no
numbness/tingling	yes	no
other_____________________		

Endocrine

excessive thirst	yes	no
too hot/cold	yes	no
tired/sluggish	yes	no
other______________________		

Gastrointestinal

abdominal pain	yes	no
nausea/vomiting	yes	no
indigestion/heartburn	yes	no
other______________________		

Cardiovascular

heart trouble	yes	no
chest pain	yes	no
ankle swelling	yes	no
high blood pressure	yes	no
other______________________		

Psychologic

Are you generally satisfied with your life?	yes	no
Do you feel severely depressed?	yes	no
Have you considered suicide?	yes	no
other______________________		

Integumentary

skin rash	yes	no
boils	yes	no
persistent itch	yes	no
other _____________________		

Allergic/Immunologic

hay fever	yes	no
drug/food allergies	yes	no
other______________________		

Musculoskeletal

joint pain	yes	no
neck pain	yes	no
back pain	yes	no
other______________________		

Ears/Nose/Throat/Mouth

ear infection	yes	no
sore throat	yes	no
sinus problems	yes	no
other______________________		

Genitourinary

urinary retention	yes	no
painful urination	yes	no
urinary frequency	yes	no
other______________________		

Respiratory

wheezing	yes	no
frequent cough	yes	no
shortness of breath	yes	no
other______________________		

Hematologic/Lymphatic

bleeding problems	yes	no
swollen glandsyes	no	
blood clotting	yes	no
other______________________		

Is there anything else you need to discuss with your doctor?	yes	no

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Physician ____ Date _______/________/_______