Bellevue Urology Associates

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, discharge, protein, sugar in urine?	□Yes	□No
Venereal disease?	□Yes	□No
Previous x-ray/ultrasound/CT scan of kidneys?	□Yes	□No

MEDICATIONS: List current medications (including aspirin, if applicable)

MEDICINE	DOSE
____________________	_________
____________________	_________
____________________	_________
____________________	_________
____________________	_________
____________________	_________
____________________	_________

PAST SURGICAL HISTORY: List previous surgeries

SURGERY	DATE	WHERE
___________	_________	____________
___________	_________	____________
___________	_________	____________
___________	_________	____________
___________	_________	____________

ALLERGIES (PLEASE CIRCLE): Penicillin Sulfa IVP dye Demerol Morphine
Codeine Betadine/Iodine Latex Tetracycline Other:_________________

PAST MEDICAL HISTORY (PLEASE CIRCLE): diabetes high blood pressure heart attack stroke cancer
kidney disease lung disease urinary infection hepatitis Other:__________________

FAMILY HISTORY:

Do any family members have (circle):

Cancer	Yes	No	Who: _____________	Diabetes	Yes	No	Who: ____________
Stroke	Yes	No	Who: _____________	Heart Disease	Yes	No	Who: ____________
Kidney Disease	Yes	No	Who: _____________	Other: __________________			Who: ____________

Mother alive: Yes No Age at death: ________ Father Alive: Yes No Age at death: ______

SOCIAL HISTORY:

Occupation____

Do you drink alcohol? Yes: __________how much No

Do you smoke? Yes: __________how much No Previous smoker? (circle one) Yes No

PLEASE TURN OVER & COMPLETE OTHER SIDE

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 ________________________

Ear/Nose/Throat/Mouth

Ear infection	yes	no
Sore throat	yes	no
Sinus problems	yes	no

Other ________________________

Cardiovascular

Heart trouble	yes	no
Chest pain	yes	no
Ankle swelling	yes	no
High blood pressure	yes	no

Other________________________

Respiratory

Wheezing	yes	no
Frequent cough	yes	no
Shortness of breath	yes	no

Other ________________________

Gastrointestinal

Abdominal pain	yes	no
Nausea/vomiting	yes	no
Indigestion/heartburn	yes	no

Genitourinary

Urinary retention	yes	no
Painful urination	yes	no
Urinary frequency	yes	no

Integumentary

Skin rash	yes	no
Boils	yes	no
Persistent itch	yes	no

Other________________________

Neurological

Tremors	yes	no
Dizzy spells	yes	no
Numbness/tingling	yes	no

Other ________________________

Musculoskeletal

Joint pain	yes	no
Neck pain	yes	no
Back pain	yes	no

Other ________________________

Endocrine

Excessive thirst	yes	no
Too hot/too cold	yes	no
Tired/sluggish	yes	no

Other_________________________

Psychological

Are you generally satisfied with your life? yes no

Do you feel severely depressed? yes no

Have you considered suicide? yes no

Hematologic/Lymphatic

Bleeding problems	yes	no
Swollen glands	yes	no
Blood clotting	yes	no

Other ________________________

Allergic/Immunologic

Hay fever	yes	no
Drug/food allergies	yes	no

Other ________________________

If there is anything else you need to discuss with your doctor? ______________________________________

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Nurse use only: BP _____/_____ Pulse: ________Temp: _______ Weight: ________ Height: ________