Associated Urologists of North Carolina

New/Returning Patient History Form

Note:This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date_____________ Date of Last Physical Exam ___________________ Referring MD ___________________ Family MD ___________________

Last Name ____ First Name _________________________________ Middle _____________________

Social Security Number ____ Date of Birth ________________________________Age_____________

Chief Complaint - What is the main reason for your visit today? ____

____

For Return Patients Only

There have been no changes in my History of Present Illness unless noted below.

Signature_________________________ Date ___________

History of Present Illness

Please answer the following questions

Location of the problem
Abdomen ☐ Back ☐ Groin ☐
Other _____________________________________
____
____

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

When did you first notice the problem?
2 Days Ago☐ 2 Weeks Ago ☐ 1 Month Ago ☐ Other _________
____

Does anything help or make the problem worse?
Moving around☐Standing up☐Lying on my side☐Urinating☐
Bowel Movement☐Other ___________________________

Does anything make it less severe or go away? Moving, Position☐
Urinating☐Other ________________________________

Have the symptoms changed over time?
No ☐ Yes ☐ If yes, please explain __________________________

How long does the problem last?
30 Minutes ☐ 1 Hour ☐ It is always there ☐
Other ____

Is anything also occurring at the same time?
No ☐Yes☐ If yes, please explain.
Other ____

Is the problem constant? Yes ☐ No☐
If not, describe ____
Dull then sharp ☐ Very sharp then leaves☐ Always there☐
Other ____

Does the problem interfere with your normal functions? No ☐ Yes ☐
If yes, please explain _____________________________________

Physician Use Only

Past Medical, Social History, Family History

List any personal past illness and/or surgeries and when they occurred.

Illness/Surgery	Date

Do you use tobacco products? No☐Yes☐If yes, type/amt.?__________
How long? ________ Quit?☐When?________ Years of use?________

Do you drink alcohol? No☐Yes☐If yes, how much? _______________

Do you consume caffeine? No☐ Yes☐ If yes, how much? __________

Type of work (describe activity level) __________________________

Are you ☐ single ☐ married ☐ widowed ☐ separated/divorced?
Children? ☐______

Have you seen a urologist before? No☐Yes☐
If yes, whom and reason ___________________________________

Physician Use Only

Patient History Form

Please complete other side

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Do you take any medications/herbs/supplements? No ☐ Yes ☐ If yes, list name and dose Pharmacy/location_________________ Phone________________

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

Do you have any allergies? No ☐ Yes ☐ If yes, please explain _________________

Do you take aspirin daily? No ☐ Yes ☐

Are you on a special diet? No ☐ Yes ☐ If yes, please explain _________________

Artificial heart valve? No ☐ Yes ☐ Artificial joint? No ☐ Yes ☐
Cardiac stent? No ☐ Yes ☐ Prophylaxis required? No ☐ Yes ☐

Would your religion in any way interfere with your medical care? No ☐ Yes ☐ If yes, please explain ________________________________

List all serious illnesses in your immediate family (e.g. diabetes, heart disease, kidney disease, kidney stones, prostate cancer, etc)

____

____

For Return Patients Only

There have been no changes in my Review of Symptoms unless noted below.

Signature___________________ Date __________

Review of Symptoms

Within the past six months, have you had any problems with any of the following? Please circle yes or no for each condition. If yes, please explain.

Check here if all answers are No ☐

Constitutional Symptoms
- Fever ☐ No ☐ Yes ________________
- Chills ☐ No ☐ Yes ________________
- Headache ☐ No ☐ Yes ________________
- Other ________________

Eyes
- Blurred Vision ☐ No ☐ Yes ________________
- Double Vision ☐ No ☐ Yes ________________
- Pain ☐ No ☐ Yes ________________
- Other ________________

Allergic/Immunologic
- Hay Fever ☐ No ☐ Yes ________________
- Drug Allergies ☐ No ☐ Yes ________________
- Other ________________

Neurological
- Tremors ☐ No ☐ Yes ________________
- Dizzy Spells ☐ No ☐ Yes ________________
- Numbness/Tingling ☐ No ☐ Yes ________________
- Weakness ☐ No ☐ Yes ________________
- Other ________________

Endocrine
- Excessive Thirst ☐ No ☐ Yes ________________
- Too Hot/Cold ☐ No ☐ Yes ________________
- Tired/Sluggish ☐ No ☐ Yes ________________
- Change In Clothing Size ☐ No ☐ Yes ________________
- Other ________________

Gastrointestinal
- Abdominal Pain ☐ No ☐ Yes ________________
- Nausea/Vomiting ☐ No ☐ Yes ________________
- Indigestion/Heartburn ☐ No ☐ Yes ________________
- Diarrhea ☐ No ☐ Yes ________________
- Constipation ☐ No ☐ Yes ________________
- Other ________________

Cardiovascular
- Chest Pain ☐ No ☐ Yes ________________
- Varicose Veins ☐ No ☐ Yes ________________
- High Blood Pressure ☐ No ☐ Yes ________________
- Other ________________

Integumentary
- Skin Rash ☐ No ☐ Yes ________________
- Boils ☐ No ☐ Yes ________________
- Persistent Itch ☐ No ☐ Yes ________________
- Other ________________

Musculoskeletal
- Joint Pain ☐ No ☐ Yes ________________
- Neck Pain ☐ No ☐ Yes ________________
- Back Pain ☐ No ☐ Yes ________________
- Other ________________

Ear/Nose/Throat/Mouth
- Ear Infection ☐ No ☐ Yes ________________
- Sore Throat ☐ No ☐ Yes ________________
- Sinus Problems ☐ No ☐ Yes ________________
- Other ________________

Genitourinary
- Urine Retention ☐ No ☐ Yes ________________
- Painful Urination ☐ No ☐ Yes ________________
- Urinary Frequency ☐ No ☐ Yes ________________
- Weak Stream ☐ No ☐ Yes ________________
- Strong Urge to Void ☐ No ☐ Yes ________________
- Get Up At Night To Void ☐ No ☐ Yes ________________
- Other ________________

Respiratory
- Wheezing ☐ No ☐ Yes ________________
- Frequent Cough ☐ No ☐ Yes ________________
- Shortness of Breath ☐ No ☐ Yes ________________
- Other ________________

Hematologic
- Swollen Glands ☐ No ☐ Yes ________________
- Blood Clotting Problem ☐ No ☐ Yes ________________
- Other ________________

Psychologic
- Are you generally satisified with your life ☐ No ☐ Yes ________________
- Do you feel severly depressed? ☐ No ☐ Yes ________________
- Have you considered suicide? ☐ No ☐ Yes ________________
- Other ________________

Physician Use Only

Physician Signature Date