LAFAYETTE
Clinic of Urology
A UNITY HEALTHCARE PARTNER

Patient History Form

Todays Date:_____/_____/_____ Date of Last Physical Exam:_____/_____/_____
Last Name:_____ First Name:_____Middle:_____
Date of Birth:_____/_____/_____ Age:_____

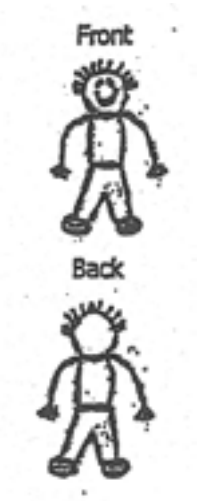
Chief Complaint:

What is the main reason for your visit today? Describe your problem in detail.)_____
_____
_____

History of Present Illness:

Please answer the following questions:

Location of the problem:
□ Abdomen □ Back □ Leg
Other_____
_____
_____



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

When did you 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
Other_____

How long does the problems last?
□ 30 minutes □ 1 hour □ It is always there.
Other_____

Is there anything else occurring at the same time?
□ Yes □ No If Yes, please explain_____
_____

□ Nausea □ Rash □ Headaches
Other_____

Is the problem: □ Constant □ Variable
□ Dull then Sharp □ Very Sharp then Leaves
□ Always There
Other_____

Does the problem interfer with your normal functions?
□ Yes □ No If Yes, please explain_____
_____

Physician Use Only: (Comments/Notes)

#Answers	Level of Service
1-3	1 or 2
4+	3-5

Past Medical & Social History:

List all serious illnesses in your immediate family. (Example: Diabetes, Tuberculosis, Prostate Cancer, Heart Disease, Etc.)
_____
_____

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

Illness or Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you smoke? □ Yes □ No If Yes, how much?_____
Do you drink? □ Yes □ No If Yes, how much?_____

Are you on any medications? □ Yes □ No If Yes, please list.
_____
_____
_____

Are you on a special diet? □ Yes □ No If Yes, please explain.
_____

Do you have allergies? □ Yes □ No If Yes, please explain.
_____

Physician Use Only: (Comments/Notes)

#Answers	Level of Service
0	1 or 2
1-2	3
3	4 or 5

Review of Systems:

Do you now or have you had any problems related to the following systems? Check Yes or No. Please explain any Yes answers in the space provided.

Constitutional Symptoms

Fever □ Yes □ No _____
Chills □ Yes □ No _____
Headache □ Yes □ No _____
Other_____

Eyes

Blurred Vision □ Yes □ No _____
Double Vision □ Yes □ No _____
Pain □ Yes □ No _____
Other_____

Allergic / Immunologic

Hay Fever □ Yes □ No _____
Drug Allergies □ Yes □ No _____
Food Allergies □ Yes □ No _____
Other_____

Neurological

Tremors □ Yes □ No _____
Dizzy Spells □ Yes □ No _____
Numbness/Tingling □ Yes □ No _____
Stroke □ 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

Chest Pain □ Yes □ No _____
Varicose Veins □ Yes □ No _____
High Blood Pressure □ Yes □ No _____
Other_____

Integumentary

Skin Rash □ Yes □ No _____
Boils □ Yes □ No _____
Persistent Itch □ Yes □ No _____
Other_____

Musculoskeletal

Joint Pain □ Yes □ No _____
Neck Pain □ Yes □ No _____
Back Pain □ Yes □ No _____
Other_____

Ear / Nose / Throat / Mouth

Ear Infection □ Yes □ No _____
Sore Throat □ Yes □ No _____
Sinus Problems □ Yes □ No _____
Other_____

Genitourinary

Urine Retention □ Yes □ No _____
Urine Leakage □ 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

Swollen Glands □ Yes □ No _____
Blood Clotting Problem □ Yes □ No _____
Bleeding Tendency □ Yes □ No _____
Other_____

Psychologic

Are you generally satisfied with your life? □ Yes □ No
Do you feel depressed? □ Yes □ No
Have you considered suicide? □ Yes □ No
Other_____

Physician Use Only: (Comments/Notes)

#Answers	Level of Service
0-1	1 or 2
2-9	3
10+	4 or 5

Physician SIgnature:_____ **Date:**_____

UNITY HEALTHCARE
NOTICE OF PRIVACY PRACTICES PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name:_____

Patient Signature:_____Date:_____