Urology Associates of Elkhart, Inc.

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Patient History Form

Urologic and Genitourinary Surgeons
Diplomates of the American Board of Urology
Fellows of the American College of Surgeons

Last Name:_____ **First:**_____ **Middle:**_____

Today's Date:_____ **Date of Birth:** _____ **Referring/Family Doctor:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

CHIEF COMPLAINT: (Reason for visit today) _____

_____

List Any Allergies

Dye	**Y**	**N**	Latex	**Y**	**N**
Iodine	**Y**	**N**	Shell Fish	**Y**	**N**

Medication Allergies:
List any medications that you are allergic to

_____
_____
_____
_____

List Any Past Surgeries

Type	Date (Year only)

Medications (Currently Taking)

Name	Amount	Times/Day

Patient's Medical History

			When Diagnosed (Year)
Diabetes	**Y**	**N**	_____
Heart Attack	**Y**	**N**	_____
Hypertension	**Y**	**N**	_____
Heart Murmur	**Y**	**N**	_____
Stroke	**Y**	**N**	_____
Tuberculosis	**Y**	**N**	_____
Asthma	**Y**	**N**	_____
Arthritis	**Y**	**N**	_____
Cancer	**Y**	**N**	Type _____

Other Medical Conditions: _____

_____
_____
_____

Social History

Occupation: _____

Do You Smoke? **Y** **N** How Much? _____

Do You Drink Alcohol? **Y** **N** How Much? _____

Family History

			Family Member
Cancer	**Y**	**N**	Type _____
Diabetes	**Y**	**N**	_____
Heart Disease	**Y**	**N**	_____
Stroke	**Y**	**N**	_____
Asthma	**Y**	**N**	_____

Review of Systems

Do you currently have any problems related to the following systems? Circle **Y**es or **N**o.

Constitutional Systems			**Gastrointestinal**			**Respiratory**		
Fever	Y	N	Abdominal Pain	Y	N	Wheezing	Y	N
Chills	Y	N	Nausea/Vomiting	Y	N	Frequent Cough	Y	N
Headache	Y	N	Heartburn	Y	N	Shortness of Breath	Y	N
Eyes			**Cardiovascular**			**Hematologic/Lymphatic**		
Blurred Vision	Y	N	Chest Pain	Y	N	Swollen Glands	Y	N
Double Vision	Y	N	Varicose Veins	Y	N	Blood Clotting Problems	Y	N
Pain	Y	N	High Blood Pressure	Y	N			
Allergic/Immunologic			**Integumentary**			**Psychological**		
Hay Fever	Y	N	Skin Rash	Y	N	Do you feel Depressed?	Y	N
Drug Allergies	Y	N	Persistent Itch	Y	N			
Neurologic			**Musculoskeletal**			**Endocrine**		
Tremors	Y	N	Joint Pain	Y	N	Excessive Thirst	Y	N
Dizzy Spells	Y	N	Neck Pain	Y	N	Too Hot/Cold	Y	N
Numbness/Tingling	Y	N	Back Pain	Y	N	Tired/Sluggish	Y	N
Ear/Nose/Throat/Mouth			**Genitourinary**			**Reproductive**		
Ear Infection	Y	N	Painful Urination	Y	N	Number of Pregnancies	_____	
Sore Throat	Y	N	Blood in Urine	Y	N	Number of Live Births	_____	
Sinus Problems	Y	N	Urinary Retention	Y	N			

1. On average, about how many times a day do you urinate? ____
2. On average, how many times during the night do you urinate? ____
3. During a typical day, how many protective pads do you wear?
   _____ diapers _____ maxi pads _____ panty liners
4. Do you leak urine at night in bed? ___ Yes _____ No
5. How often do you have such a strong urge to urinate that you expect leakage before you reach the toilet?
   _____Often _____Sometimes _____Seldom _____ Never
6. How often do you leak urine when you sneeze, cough, laugh, or exercise?
   _____Often _____Sometimes _____Seldom _____ Never
7. Which causes most of your leakage? ____above #5 _____ above #6
8. Do you have to strain to get a urine stream started? __ Yes ____ No
9. Do you feel like you empty your bladder? ___ Yes _____ No
10. Have you ever had bladder kidney infections? ___ Yes _____ No
11. How often do you experience pain or discomfort when you urinate?
    _____Often _____Sometimes _____Seldom _____ Never
12. Have you ever had surgery to correct urinary incontinence? _ Yes _____ No
13. How long have you had urinary incontinence? __ Years _____ Months

Physician:_____ **Date:**_____