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**					
Ear Infection	Y	N	Painful Urination	Y	N			
Sore Throat	Y	N	Blood in Urine	Y	N			
Sinus Problems	Y	N	Urinary Retention	Y	N			

MALE ONLY — AUA Symptom Score: Circle one number on each line

Questions to be answered	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Over the past month, how often have you had to urinate less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month, how often have you had to push or strain to begun urination?	0	1	2	3	4	5
7. On a nightly basis, how many times do you typically get up to urinate?	0	1	2	3	4	5

Sum the seven circled numbers ((AUA Symptom Score): _____ Scoring: Mild: 0-7 Moderate: 8 to 19 Severe: 20-35

Physician:_____ **Date:**_____