Health History Form

Name: _____ **Date of Birth:** ___/___/___ **Age:** _____

Do you now or have you had any of the problems listed below? Circle "Y" Yes or "N" No

Constitutional			**Genitourinary - Continued**			**GU - STDs - Continued**		
Fever	Y	N	Incomplete Void	Y	N	HIV/AIDS	Y	N
Chills	Y	N	Incontinence – Stress	Y	N	Syphilis	Y	N
Fatigue/Weakness	Y	N	Incontinence – Urge	Y	N	Venereal Warts	Y	N
Other	Y	N	Kidney Stones	Y	N	Other	Y	N
Eyes			Pelvic Pain	Y	N	**Hematological/Lymphatic**		
Blurred Vision	Y	N	Urinary - Dribbling	Y	N	Blood Transfusions	Y	N
Glaucoma	Y	N	Urinary - Hesitancy	Y	N	Clotting Problems	Y	N
Vision Loss	Y	N	Urinary - Intermittency	Y	N	Hepatitis	Y	N
Other	Y	N	Urinary - Urgency	Y	N	Other	Y	N
Ears, Nose, Throat			Urinary - Weak Stream	Y	N	**Musculoskeletal**		
Ear Infection	Y	N	Urinary Infection	Y	N	Arthritis	Y	N
Sinus Problems	Y	N	Other	Y	N	Back Pain	Y	N
Sore Throat	Y	N	**Genitourinary - Female**			Joint Pain	Y	N
Other	Y	N	Cystocele	Y	N	Loss of Motion	Y	N
Respiratory			Painful Intercourse	Y	N	Other	Y	N
Asthma	Y	N	Pregency	Y	N	**Integumentary**		
COPD	Y	N	Prolapsed Bladder	Y	N	Rashes	Y	N
Tuberculosis	Y	N	Vaginal Discharge	Y	N	Skin Cancer	Y	N
Other	Y	N	Other	Y	N	Warts	Y	N
Cardiovascular			**Genitourinary - Male**			Other	Y	N
Chest Pain	Y	N	Erectile Dysfunction	Y	N	**Neurological**		
Hypertension	Y	N	Prostate Cancer	Y	N	Fainting	Y	N
Irregular Heartbeat	Y	N	Prostate – Enlarged	Y	N	Seizures	Y	N
Other	Y	N	Prostatitis	Y	N	Stroke	Y	N
Gastrointestinal			PSA - Abnormal	Y	N	Other	Y	N
Abdominal Pain	Y	N	Semen - Bloody	Y	N	**Psychiatric**		
Indigestion	Y	N	Testicle Mass	Y	N	Anxiety	Y	N
Nausea/Vomiting	Y	N	Testicular Pain	Y	N	Dementia	Y	N
Other	Y	N	Foreskin Problems	Y	N	Depression	Y	N
Genitourinary			Vasectomy	Y	N	Other	Y	N
Bedwetting	Y	N	Other	Y	N	**Endocrine**		
Blood in Urine	Y	N	**Genitourinary - STDs**			Abnormal Thyroid	Y	N
Decreased Sex Drive	Y	N	Chlamydia	Y	N	Diabetes	Y	N
Flank Pain	Y	N	Genital Herpes	Y	N	Excessive Thirst	Y	N
Frequent Urination	Y	N	Gonorrhea	Y	N	Other	Y	N

Physican Comments:

Revised: 02/21/06

Health History Form

Name: _____ **Date of Birth:** ___/___/___ **Age:** _____

Past Medical History

Surgery	Date	Location	Illness	Year

Family Medical History	Father	Mother	Brother(s)	Sister(s)
Bladder Cancer	☐	☐	☐	☐
Cardiac Disease	☐	☐	☐	☐
Congenial Urological Conditions	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Kidney Cancer	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐
Renal Stone	☐	☐	☐	☐

Social History

Alcohol Use:
- ☐ Do not use
- ☐ Social Drinker
- ☐ Beer = Amount _____
- ☐ Wine = Amount _____
- ☐ Liquor = Amount _____

Tobacco Use:
- ☐ Do not smoke
- ☐ Cigarettes = Number of years_____
- ☐ Quit smoking = Number of years_____
- ☐ Have smoker in the home
- ☐ Other _____

Caffeine:
- ☐ Do not use
- ☐ Coffee = _____ amount per day
- ☐ Cola = _____ amount per day
- ☐ Tea = _____amount per day

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widow(er)

Employment:
- ☐ Unemployed
- ☐ Student
- ☐ Child/Infant
- ☐ Employed _____
- ☐ Retired / *Occupation*

History Given By:
- ☐ Self
- ☐ Spouse
- ☐ Parent
- ☐ Caregiver
- ☐ Guardian/POA
- ☐ Medical Records

Known Allergies:

Patient's Signature:_____ Date: ___/___/___

Physician's Signature:_____ Date: ___/___/___

Revised: 02/21/06