

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	Pregnancy 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
Physician Comments:		

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Past Medical History

Surgery	Date	Location	Illness	Year

Family Medical History	Father	Mother	Brother(s)	Sister(s)
Bladder Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Urological Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal Stone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

<p>Alcohol Use:</p> <input type="checkbox"/> Do not use <input type="checkbox"/> Social Drinker <input type="checkbox"/> Beer = Amount _____ <input type="checkbox"/> Wine = Amount _____ <input type="checkbox"/> Liquor = Amount _____ <p>Tobacco Use:</p> <input type="checkbox"/> Do not smoke <input type="checkbox"/> Cigarettes = Number of years _____ <input type="checkbox"/> Quit smoking = Number of years _____ <input type="checkbox"/> Have smoker in the home <input type="checkbox"/> Other _____ <p>Caffeine:</p> <input type="checkbox"/> Do not use <input type="checkbox"/> Coffee = _____ amount per day <input type="checkbox"/> Cola = _____ amount per day <input type="checkbox"/> Tea = _____ amount per day	<p>Marital Status:</p> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) <p>Employment:</p> <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Child/Infant <input type="checkbox"/> Employed \ _____ <input type="checkbox"/> Retired / _____ <i>Occupation</i> <p>History Given By:</p> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Caregiver <input type="checkbox"/> Guardian/POA <input type="checkbox"/> Medical Records
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Known Allergies:

Patient's Signature: _____

Date: ___/___/___

Physician's Signature: _____

Date: ___/___/___