PAST MEDICAL & SOCIAL HISTORY

Name:____ Date:______________________

Date of Birth:_____________________________________

PAST MEDICAL HISTORY

Glaucoma	Yes	No	Joint/Valve Replacement	Yes	No	Heart Murmur	Yes	No
Pneumonia	Yes	No	Congestive Heart Failure	Yes	No	Bronchitis	Yes	No
Emphysema	Yes	No	Bleeding Tendency	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Kidney Disease	Yes	No	COPD	Yes	No
Liver Disease	Yes	No	Neurological Disease	Yes	No	Stroke	Yes	No
AIDS	Yes	No	Mental Health Disease	Yes	No	Muscle Disease	Yes	No
Cancer	Yes	No	Rheumatic Fever	Yes	No	Heart Disease	Yes	No
Nerve Disorder	Yes	No	Diabetes	Yes	No	Hypertension	Yes	No

Other____

____

PAST SURGICAL HISTORY

Stones	Yes	No	Kidney Tumor	Yes	No
Bladder Infection	Yes	No	Prostate Cancer	Yes	No
Bladder Tumor	Yes	No			

Any previous urological Surgery? Yes No

If yes, when and what procedure?____

____

____

PAST SURGICAL HISTORY

PAST SURGICAL HISTORY	When
____	_________________________
____	_________________________
____	_________________________
____	_________________________
____	_________________________

PATIENT SOCIAL HISTORY

Environmental Exposure_______________________________

Use of Tobacco:_____Never_____Previously, but quit in_____Currently_____Packs/day ___Years

Use of Alcohol:_____Never_____Rarely_____Moderate____Daily

Use of Drugs: Yes_____No_______If yes, Type________________________Frequency__________________

Use of Caffeine:_____Never_____Rarely_____Daily_____________cups/day

FAMILY MEDICAL HISTORY

	Alive/Deceased	Age	Disease/Condition	If deceased, cause of death
Father	______________	_______	____________________	__________________________
Mother	______________	_______	____________________	__________________________
Siblings	______________	_______	____________________	__________________________
Children	______________	_______	____________________	__________________________

Does the father have Prostate Cancer? Yes No

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Circle Yes or No

Please explain any yes answers in the space provided

Constitutional Symptoms

Fever Y N

Chills Y N

Headache Y N

Other______________________________

Eyes

Blurred vision Y N

Double vision Y N

Pain Y N

Other______________________________

Allergic/Immunologic

Hay fever Y N

Drug allergies Y N

Other______________________________

Neurological

Tremors Y N

Dizzy spells Y N

Numbness/tingling Y N

Other______________________________

Endocrine

Excessive thirst Y N

Too hot/cold Y N

Tired/sluggish Y N

Other______________________________

Gastrointestinal

Abdominal pain Y N

Nausea/vomiting Y N

Indigestion/heartburn Y N

Other______________________________

Cardiovascular

Chest pain Y N

Varicose veins Y N

High blood pressure Y N

Other______________________________

Integumentary

Skin rash Y N

Boils Y N

Persistent itch Y N

Other______________________________

Musculoskeletal

Joint pain Y N

Neck pain Y N

Back pain Y N

Other______________________________

Ear/Nose/Throat/Mouth

Ear infection Y N

Sore throat Y N

Sinus problems Y N

Other______________________________

Genitourinary

Urine retention Y N

Painful urination Y N

Urinary frequency Y N

Other______________________________

Respiratory

Wheezing Y N

Frequent cough Y N

Shortness of breath Y N

Other______________________________

Hematologic/Lymphatic

Swollen glands Y N

Blood clotting problem Y N

Other______________________________

Psychologic

Are you generally satisfied with your life? Y N

Do you feel severely depressed? Y N

Have you considered suicide? Y N

Other______________________________

Current Medications and Dosages:____

____

____

Allergies:____

____

I have read the above. This information is current and true___________________________

Patient signature Date