

Urological Surgery, P.A.
44 Birch St., Suite 303
Derry, New Hampshire 03038

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE: _____ REFERRING OR PRIMARY M.D. _____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

DATE OF BIRTH _____ AGE _____ MARITAL STATUS _____

CHIEF COMPLAINT: What is the main reason for your visit today? (Describe your problem in detail) _____

History of Present Illness Please answer the following questions

Location of the problem

Abdomen Back Leg

Other: _____

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other: _____

Does anything help or make the problem worse?

Moving around Standing up Lying on my side

Other: _____

How long does the problem last?

30 minutes 1 hour It is always there

Other: _____

Is anything else occurring at the same time?

Yes No If yes, please explain. _____

Nausea Rash Headaches

Other: _____

Is the problem constant or variable?

Dull then sharp Very sharp then leaves Always there

Other: _____

Does the problem interfere with your normal functions? Yes No If yes, please explain _____

Physician use only:

Hematuria: Gross / Micro

Dysuria / Hesitancy / Nocturia

Urgency / Frequency

Strang / PV Dribbling

Stream Sput-FOC

PSS / QOL

UTI / STD / Urouth /D /C

Erex / Ejac

Incont Stress-Urge

PSA

LMP

G P

B.C.

Vag

PAP

AB

Infex

Mammo

CSEX/NSVD

List any personal past medical illnesses (high blood pressure, diabetes, high cholesterol, etc.) _____

List any personal past surgeries (include vasectomy): _____

List any medications that you take (include aspirin, herbs, vitamins or Saw Palmetto): _____

Do you have any drug allergies: _____ History of STD (Herpes, AIDS, Hep. C, etc): _____

Do you smoke? Y N If yes, how much? - _____ Do you drink? Y N If yes, how much? _____

Do you use any drugs? Y N _____ Do you use any caffeine? Y N If yes, how much? _____

List all serious illnesses in your immediate family (heart disease, diabetes, prostate cancer, etc.): _____

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 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/immunological

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 _____		

Hematological/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

Psychological

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other _____		

Physician use only:

IMP:

U/A

DIP

pH

Gluc

Blood

Protein

MICRO

BACT

RBC

WBC

Crystals

+/- U/C

PLAN:

Physician / PAC: _____ Date _____