Columbia Urological Associates, P.A.

PATIENT HISTORY FORM

MRN:_____ **DOB:**_____

Patient Name:_____

Date:_____

Medical Doctor/PCP:_____

Who referred you?_____

Why are you here today?_____

Allergies: Please list all allergies

Penicillin **Sulfa Drugs** **Codeine** **Cipro** **Mycins**

Others:_____

Medications: Please list all medication including dosage and instructions

_____

_____

_____

_____

Primary Pharmacy Preference (Name and Number):_____

Surgical History: (Circle all that apply)

Cystoscopy	Appendix	Hernia Repair	Other Surgeries:
Bladder Surgery	Defibrillator	Hip Surgery	_____
Kidney Stone Surgery	Gall Bladder	Hysterectomy	_____
Lithotripsy	Heart Bypass	Joint Replacement	_____
Prostate Biopsy	Heart Stent	Knee Surgery	_____
Prostate Surgery	Heart Valve	Lumbar Disc	_____
		Pacemaker	_____

Medical Problems: Circle all that Apply:

Bladder Cancer	Anxiety	Endometriosis	Stroke
UTIs	Atrial Fibrillation	GERD	Cancer:_____
Elevated PSA	Congest. Heart Failure	Heart Attack	
Enlarged Prostate	Depression	High Blood Pressure	Other Medical Problems:
Kidney Cancer	Hepatitis	High Cholesterol	_____
Kidney Stones	Diabetes	HIV	_____
Prostate Cancer	Diverticulitis	Kidney Failure	_____
Blood in Urine	Emphysema	Mitral Valve Prolapse	_____

Family History: (Circle all that Apply)

Kidney Cancer	Anesthesia Reactions
Kidney Stones	Bleeding Disorder
Prostate Cancer	Sickle Cell Anemia

Social History: (Circle all that Apply)

Status: Single Married Widow Divorced Other

Tobacco Use: Current If Current: Type:_____ Packs per Day:_____

Former How many years ago did you quit?_____

Never

Alcohol Use: Current Daily Intake:_____

Former How many years ago did you quit?_____

Never

Caffeinated Drinks per Day: 0 1 2 3 4+

Employer:_____

Please continue on back side

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Language: _____
Race: White Black or African American Hispanic or Latino Asian Unknown
Ethnicity: Hispanic or Latino Not Hispanic or Latino

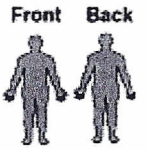
Review of Systems: (Circle all that Apply)

Constitutional:	Fever	Chills	Headache
Eyes	Blurry Vision	Double Vision	Pain
Allergic/Immunologic:	Hay Fever	Drug Allergies	
Neurological:	Tremors	Dizziness	Numbness/Tingling
Endocrine:	Excessive Thirst	Too Hot/Cold	Tired/Sluggish
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Indigestion/Heartburn
Cardiovascular:	Chest Pains	Varicose Veins	High Blood Pressure
Integumentary/Skin:	Skin Rash	Boils	Persistent Itching
Musculoskeletal:	Joint Pain	Neck Pain	Back Pain
Ear/Nose/Throat/Mouth:	Ear Infection	Sore Throat	Sinus Problems
Genitourinary:	Urine Retention	Painful Urination	Urinary Frequency
Respiratory:	Wheezing	Frequent Cough	Shortness of Breath
Hematologic/Lymphatic:	Swollen Glands	Blood Clotting Problem	
Psychologic:	Depression	Suicidal Thoughts	

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 _____

Patient Signature: _____