Patient History Form

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 _____ /_____ / 201____ **Date of Birth** _____ /_____ /_____ **SS#** _____-_____-_____

Last Name _____ **First** _____ **Middle**_____

CHIEF COMPLAINT

What is the main reason for your visit today? _____

_____

What previous treatment have you had for this problem? By which doctor?

_____

PAST MEDICAL HISTORY

Please circle any illnesses that you have had in the past or present, treated or untreated.

Diabetes Heart Disease Emphysema (COPD) High Blood Pressure
Glaucoma Cancer *(specify type)* _____

Any other illnesses? *(list)* _____

For women: Date of last menstrual period: _____ /_____/_____ Number of children _____

PAST SURGICAL HISTORY

Please circle any operations that you have had.

Hysterectomy (removal of uterus) Bladder Surgery Prostate Surgery
C Section Joint Replacement Heart Valve Replacement Pacemaker

Please list other operations: _____

_____

FAMILY HISTORY

Please list serious illnesses in immediate family members (parents, siblings, and children)

Father _____ Mother _____ Other _____

For men: *Please list any immediate family members with prostate cancer* _____

If parents are deceased, please list age and cause of death for each _____

_____

SOCIAL HISTORY

What is or was your job? _____

Do you currently smoke? Y / N If not, have you ever smoked? Y / N
If yes to either question: How many packs per day did you smoke?_____ packs/day
How many years did you smoke? _____ years

Do you drink alcohol? Y / N If yes how much?

ALLERGIES

Please list medications that you have a reaction to and the type of reaction. If none write ***"none".***

Medication	**Reaction**	**Medication**	**Reaction**
_____	_____	_____	_____
_____	_____	_____	_____

Doctor notes: _____

_____

PLEASE COMPLETE OTHER SIDE

PINELLAS UROLOGY, INC
Review of Systems

Pt. Name: _____ SS# _____ - _____ - _____

Have you ever had any **SIGNIFICANT, PERSISTING** problems with the following?
Circle **Y**es or **N**o.

General / Constitutional

Headache	Y	N
Chills	Y	N
Fever	Y	N

Allergic / Immunologic

Hay fever	Y	N
Drug Allergies	Y	N

Ophthalmologic

Blurring of vision	Y	N
Double vision	Y	N
Glaucoma	Y	N

HEENT / Neck

Ear Infection	Y	N
Sinus Problems	Y	N
Sore Throat	Y	N

Endocrine

Excessive Thirst	Y	N
Too Hot / Too Cold	Y	N
Fatigue	Y	N

Respiratory

Cough	Y	N
Shortness of breath	Y	N
Wheezing	Y	N

Cardiovascular

Chest pain	Y	N
High Blood Pressure	Y	N
Varicose Veins	Y	N

Gastrointestinal

Abdominal pain	Y	N
Heartburn / Indigestion	Y	N
Nausea / vomiting	Y	N

Urologic

Urinary Retention	Y	N
Painful Urination	Y	N
Urinary Frequency		

Neurologic

Dizziness	Y	N
Numbness / Tingling	Y	N
Tremors	Y	N

Musculoskeletal

Neck Pain	Y	N
Back Pain	Y	N
Joint Pain	Y	N

Dermatologic

Boils	Y	N
Itching	Y	N
Rash	Y	N

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problems	Y	N

Psychiatric

Insomnia	Y	N
Anxiety	Y	N
Depression	Y	N

Other: _____

_____

Physician
Signature: _____ Date: _____ /_____ /_____

PLEASE COMPLETE OTHER SIDE