



ADVANCED UROLOGY INSTITUTE
ANNUAL VISIT – PATIENT HISTORY FORM

NAME _____ TODAY'S DAY _____ DATE OF BIRTH _____

NAME OF YOUR PRIMARY CARE DOCTOR _____

CHIEF COMPLAINT/REASON OF VISIT _____

PHARMACY NAME AND LOCATION _____

ALLERGIES TO ANY MEDICATIONS, FOODS OR IV CONTRAST/X-RAY DYE _____

PLEASE COMPLETE YOUR MOST CURRENT MEDICATION LIST:

Name of Medication/Over the Counter meds/Vitamins/Herbal Meds	Strength	# of times taken per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PAST MEDICAL HISTORY

PLEASE LIST ANY NEW MEDICAL PROBLEMS OR SURGERIES YOU HAVE HAD IN THE PAST YEAR (OR SINCE YOUR LAST VISIT)



ADVANCED UROLOGY INSTITUTE
ANNUAL VISIT - PATIENT HISTORY FORM

NAME _____ TODAY'S DAY _____ DATE OF BIRTH _____

SOCIAL HISTORY:

Do you smoke cigarettes? _____ NO _____ YES How many packs per day? _____

If NO, have you ever smoked? _____ NO _____ YES - When did you quit? _____

Do you drink alcohol? _____ Never _____ Occasional _____ Daily - # of Drinks per day _____

ARE YOU: _____ MARRIED _____ DIVORCED _____ SINGLE (NEVER MARRIED) _____ WIDOWED

REVIEW OF SYSTEMS: Please check YES or NO

General/Constitutional

- Headache ()Yes ()No
Chills ()Yes ()No
Fever ()Yes ()No

Neurologic

- Dizziness ()Yes ()No
Numbness/Tingling ()Yes ()No
Tremor ()Yes ()No

Ophthalmologic

- Blurring of Vision ()Yes ()No
Double Vision ()Yes ()No
Eye Pain ()Yes ()No
Glaucoma ()Yes ()No

Musculoskeletal

- Neck Pain ()Yes ()No
Back Pain ()Yes ()No
Joint Pain ()Yes ()No

HEENT/Neck

- Ear Infection ()Yes ()No
Sinus Problems ()Yes ()No
Sore Throat ()Yes ()No

Dermatologic

- Boils ()Yes ()No
Itching ()Yes ()No
Rash ()Yes ()No

Endocrine

- Excessive thirst ()Yes ()No
Too hot/too cold ()Yes ()No
Fatigue ()Yes ()No

Hematology

- Swollen Glands ()Yes ()No
Blood Clotting problem ()Yes ()No

Respiratory

- Cough ()Yes ()No
Shortness of breath ()Yes ()No
Wheezing ()Yes ()No

Psychiatric

- Insomnia ()Yes ()No
Anxiety ()Yes ()No
Depression ()Yes ()No

Cardiovascular

- Chest Pain ()Yes ()No
High Blood Pressure ()Yes ()No
Varicose Veins ()Yes ()No

Gastrointestinal

- Abdominal Pain ()Yes ()No
Heartburn/Indigestion ()Yes ()No
Nausea/Vomiting ()Yes ()No

Urologic

- Urinary Retention ()Yes ()No
Painful Urination ()Yes ()No
Urinary Frequency ()Yes ()No

COMMENTS: _____

