



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)



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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: _____

