Urology Patient History Form

Community Memorial HEALTHCARE

Patient Name _____

Date of Birth _____

Please list previous surgeries.

_____

_____

_____

_____

_____

_____

Please list all medications you are currently taking.

_____

_____

_____

_____

_____

_____

Community Memorial Urology

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Urology Patient History Form

Patient Label

Patient Name: _____

Date of Birth: _____

Referred by: _____

Married: _____ Divorced: _____ Widowed: _____ Single: _____ Number of children: _____

What is your main symptom(s) (problem) at present? _____

_____

Urologic History:

YES NO

- ☐ ☐ Urinary tract infections?
- ☐ ☐ Kidney or bladder stones?
- ☐ ☐ Blood in the urine?
- ☐ ☐ Pus in the urine?
- ☐ ☐ Protein in the urine?
- ☐ ☐ Sugar in the urine?
- ☐ ☐ Incontinence (loss of urine) or bedwetting?
- ☐ ☐ X-rays of kidneys?
- ☐ ☐ Previous urologic tests or procedures?
- ☐ ☐ Other

Past Medical History (Please circle any of the following if you have/had the disease.)

Anemia	Arthritis	Asthma or hay fever	Bone or joint disease
Cancer	Chest pain	Colitis	Diabetes
Diphtheria	Epilepsy	Glaucoma	Gonorrhea or syphilis
Gout	Heart attack	Heart disease	High blood pressure
Hives or eczema	Jaundice	Kidney disease	Liver disease
Lung disease	Migraine headaches	Nervous disorder	Pneumonia
Rheumatic fever	Rheumatism	Scarlet fever	Smallpox
Stroke	Tuberculosis		

Urology Patient History Form

Previous injury? _____

_____

Hospitalizations? _____

_____

Pregnancy? (How many?) _____

Have you had a recent cardiogram or chest X-ray? _____

Habits? (tobacco, alcohol, coffee, other) _____

Family History (Any family members who have had the following diseases?)

Cancer _____

Diabetes _____

Heart disease _____

Kidney stones _____

Tuberculosis _____

Other _____