

PATIENT HISTORY FORM

NAME: _____ DATE: _____

DATE OF BIRTH: _____ REFERRING PHYSICIAN: _____

CHIEF COMPLAINT

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (DESCRIBE YOUR PROBLEM IN DETAIL)

HISTORY OF PRESENT ILLNESS

LOCATION OF THE PROBLEM

ABDOMEN BACK SCROTUM PENIS VAGINA

OTHER: _____

DOES ANYTHING MAKE THE PROBLEM WORSE? Y N

DOES ANYTHING MAKE THE PROBLEM BETTER? Y N

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

IS ANYTHING OCCURRING AT THE SAME TIME? Y N

IF YES PLEASE EXPLAIN _____

WHEN DID YOU FIRST NOTICE THE PROBLEM?

_____ DAYS AGO _____ WEEKS AGO _____ MONTHS AGO

OTHER: _____

IS THE PROBLEM CONSTANT OR VARIABLE? Y N

IF YES PLEASE EXPLAIN _____

HOW LONG DOES THE PROBLEM LAST?

_____ MINUTES _____ HOURS ALWAYS THERE

OTHER: _____

DOES IT INTERFERE WITH YOUR NORMAL DAILY ROUTINE?

Y N IF YES PLEASE EXPLAIN _____

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

LIST ANY ILLNESS, HOSPITALIZATION OR SURGERY.

DATE

LIST ALL SERIOUS ILLNESSES IN YOUR IMMEDIATE FAMILY.

CONDITION

HOW RELATED

CANCER

Y N

DIABETES

Y N

THYROID

Y N

STROKE

Y N

ULCERS

Y N

ARE YOU ON ANY MEDICATIONS? (INCLUDING OTC) Y N

NAME DOSE HOW OFTEN?

DO YOU SMOKE? YES NEVER QUIT

HOW MUCH? _____ HOW LONG? _____

DO YOU DRINK? YES NEVER QUIT

HOW MUCH? _____ HOW LONG? _____

DO YOU HAVE ANY ALLERGIES?

CONTRAST DYE OR IODINE? Y N

LATEX? Y N

MEDICATIONS? Y N

IF YES, PLEASE LIST BELOW: _____

DO YOU TAKE ASPIRIN OR BLOOD THINNERS? Y N

ARE YOU ON A SPECIAL DIET? Y N

OAKLAND COUNTY UROLOGISTS, P.C.