ColumbiaDoctors | *Urology*

PATIENT MEDICAL HISTORY

Name: ____
Last **First** **Middle Initial**

REFERRING PHYSICIAN

Referring Physician Name ______________________

Referring Physician Address ______________________

____
City State Zip Code

Referring Physician Phone ______________ Fax: ______________

Primary Care Physician (if different) ______________ Phone: ______________

What is the reason for your visit today? ______________________

When did you first notice the problem? ______________________

Have you seen any doctors for this problem? ☐ Yes ☐ No

Physician's name: ______________________

If you are a women: When was your last menstrual period? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you using any form of birth control medication? ☐ Yes ☐ No

PHARMACY INFORMATION

Pharmacy Name: ______________ Pharmacy Phone: ______________

Pharmacy Address: ______________ Pharmacy Fax: ______________

____
City State Zip Code

ALLERGIES

Do you suffer from any allergies to antibiotics or any other medication? ☐ Yes ☐ No

If YES, please provide

Medication Name: Reaction:

____

____

____

CURRENT MEDICATIONS

Please list ALL of your current medications below (use back of page if you need more room) including: Aspirin, Vitamins, Supplements, etc.

Medication Name	Dose	When do you take it?	Approximate start date of medication?

PAST MEDICAL HISTORY: Please list any medical problems you have had, and any hospitalizations

Illness/Hospitalization	Date

PAST SURGICAL HISTORY: List any surgeries you have had and the approximate date:

Surgical Procedure	Date

Have you had a blood transfusion? ☐ Yes ☐ No If yes, when? ____________________

FAMILY HISTORY

Has any close family member had?

☐ Kidney Stones ☐ Prostate Cancer ☐ Bladder Cancer ☐ Other ____________________

☐ Kidney Cancer ☐ Testicular Cancer ☐ Diabetes

SOCIAL HISTORY

Occupation

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Children ☐ Yes ☐ No Ages? ____________________ Sexes ☐ Male ☐ Female

Do you exercise regularly? ☐ Yes ☐ No

Do you drink any of the following caffeinated beverages? ☐ Yes ☐ No

If so how many cups daily? Coffee _______ Tea ________ Soda _______

Smoking: Currently? ☐ Yes ☐ No Previously? ☐ Yes ☐ No Years smoked? ___________

Packs per day? ____ Other tobacco products? ______________________ Date Stopped ___________

Have/were you exposed to second hand smoke at home or work? ☐ Yes ☐ No

If yes explain ____

Other substances Alcohol ☐ Yes ☐ No Recreational drugs? ☐ Yes ☐ No

Describe use: ____

Do you or have you ever had:

CONSTITUTIONAL		**MUSCULOSKELETAL**	
All normal	☐ Yes ☐ No	All normal	☐ Yes ☐ No
Feeling poorly (malaise)	☐ Yes ☐ No	Generalized joint pain	☐ Yes ☐ No
Recent weight loss (_____ lbs)	☐ Yes ☐ No	Joint swelling	☐ Yes ☐ No
Chills	☐ Yes ☐ No	Limb pain	☐ Yes ☐ No
Feeling tired (fatigue)	☐ Yes ☐ No	Specific joint pain (Arthritis)	☐ Yes ☐ No
Recent weight gain (_____ lbs)	☐ Yes ☐ No	Joint stiffness	☐ Yes ☐ No
		Limb swelling	☐ Yes ☐ No
EYES		**INTEGUMENTARY-MALE**	
All normal	☐ Yes ☐ No	All normal	☐ Yes ☐ No
Eye pain	☐ Yes ☐ No	Skin lesions	☐ Yes ☐ No
Eyesight problems	☐ Yes ☐ No	Itching (Pruritus)	☐ Yes ☐ No
Dry eyes	☐ Yes ☐ No	Dry skin	☐ Yes ☐ No
Red eyes	☐ Yes ☐ No	Skin wound	☐ Yes ☐ No
Discharge from eyes	☐ Yes ☐ No	Change in a mole	☐ Yes ☐ No
Eye itch		An unusual growth	☐ Yes ☐ No
ENT		**INTEGUMENTARY-FEMALE**	
All normal	☐ Yes ☐ No	All normal	☐ Yes ☐ No
Earache	☐ Yes ☐ No	Skin lesions	☐ Yes ☐ No
Nosebleeds (Epistaxis)	☐ Yes ☐ No	Itching (Pruritus)	☐ Yes ☐ No
Sore throat	☐ Yes ☐ No	Dry skin	☐ Yes ☐ No
Loss of hearing	☐ Yes ☐ No	Skin wound	☐ Yes ☐ No
Nasal discharge	☐ Yes ☐ No	Change in a mole	☐ Yes ☐ No
Hoarseness	☐ Yes ☐ No	Breast lump	☐ Yes ☐ No
CARDIOVASCULAR		**NEUROLOGICAL**	
All normal	☐ Yes ☐ No	All normal	☐ Yes ☐ No
Chest pain/Angina	☐ Yes ☐ No	Confused	☐ Yes ☐ No
Heart rate is fast	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No
Pain with walking	☐ Yes ☐ No	Limb Weakness (Paresis)	☐ Yes ☐ No
Palpitations	☐ Yes ☐ No	Convulsions/Seizures	☐ Yes ☐ No

Heart rate is slow	☐ Yes ☐ No	Fainting (Syncope)	☐ Yes ☐ No
Lower extremity swelling (Edema)	☐ Yes ☐ No	Difficulty walking	☐ Yes ☐ No
GASTROINTESTINAL		**PSYCHIATRY**	
All normal	☐ Yes ☐ No	All normal	☐ Yes ☐ No
Abdominal pain	☐ Yes ☐ No	Suicidal thoughts	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Heartburn	☐ Yes ☐ No	Change in personality	☐ Yes ☐ No
Vomiting	☐ Yes ☐ No	Sleep disturbances	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Black stool (Melena)	☐ Yes ☐ No	Emotional problems	☐ Yes ☐ No
RESPIRATORY		**ENDOCRINE – FEMALE**	
All normal	☐ Yes ☐ No	All normal	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Protruding eyes (Proptosis)	☐ Yes ☐ No
Cough	☐ Yes ☐ No	Muscle weakness	☐ Yes ☐ No
Difficulty breathing lying down	☐ Yes ☐ No	Feelings of weakness	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No	Hot flashes	☐ Yes ☐ No
Difficulty breathing on exertion	☐ Yes ☐ No	Deepening of the voice	☐ Yes ☐ No
Awakening short of breath (PND)	☐ Yes ☐ No		
GENITOURINARY - FEMALE		**ENDOCRINE – MALE**	
All normal	☐ Yes ☐ No	All normal	☐ Yes ☐ No
Painful urination (Dysuria)	☐ Yes ☐ No	Protruding eyes (Proptosis)	☐ Yes ☐ No
Pelvic pain	☐ Yes ☐ No	Muscle weakness	☐ Yes ☐ No
Vaginal discharge	☐ Yes ☐ No	Feelings of weakness	☐ Yes ☐ No
Incontinence	☐ Yes ☐ No	Hot flashes	☐ Yes ☐ No
Painful period (Dysmenorrhea)	☐ Yes ☐ No	Deepening of the voice	☐ Yes ☐ No
Abnormal vaginal discharge	☐ Yes ☐ No	Erectile dysfunction	☐ Yes ☐ No

Please list any other symptoms: ____

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Patient Signature: ____

Physician Signature: ____