

North Carolina Urological Associates, Inc.

Patient History Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date _____ Date of Last Physical Exam _____ Referring MD _____ Family MD _____

Last Name _____ First Name _____ Middle _____

Social Security Number _____ Date of Birth _____ Age _____

Chief Complaint - What is the main reason for your visit today? _____

History of Present Illness

Please answer the following questions

Location of the problem
 Abdomen _____ Back _____ Groin _____
 Other _____

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

When did you first notice the problem?
 2 Days Ago _____ 2 Weeks Ago _____ 1 Month Ago _____

Does anything help or make the problem worse?
 Moving around _____ Standing up _____ Lying on my side _____ Urinating _____
 Bowel Movement _____ Other _____

Does anything make it less severe or go away? Moving, Position
 Urinating _____ Other _____

Have the symptoms changed over time?
 No Yes If yes, please explain _____

How long does the problem last?
 30 Minutes _____ 1 Hour _____ It is always there _____
 Other _____

Is anything also occurring at the same time?
 No Yes If yes, please explain.
 Nausea _____ Rash _____ Headache _____
 Other _____

Is the problem constant? Yes No
 If not, describe _____
 Dull then sharp _____ Very sharp then leaves _____ Always there _____
 Other _____

Does the problem interfere with your normal functions? No Yes
 If yes, please explain _____

Physician Use Only

Past Medical, Social History, Family History

List any personal past illness and/or surgeries and when they occurred.

Illness/Surgery	Date	Illness/Surgery	Date

Do you smoke? No Yes If yes, how much? _____

Do you drink? No Yes If yes, how much? _____

Marital Status _____ Children _____ Type of Work (describe activity level) _____

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Last Name _____ First Name _____ Middle _____

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Are you on any medication?

No Yes If yes, list all

Do you have any allergies?

No Yes If yes, please explain

Are you on a special diet?

No Yes If yes, please explain

List all serious illnesses in your immediate family (e.g. diabetes, tuberculosis, breast cancer, heart disease, etc)

Review of Symptoms

Constitutional Symptoms

Fever No Yes _____
 Chills No Yes _____
 Headache No Yes _____
 Other _____

Eyes

Blurred Vision No Yes _____
 Double Vision No Yes _____
 Pain No Yes _____
 Other _____

Allergic/Immunologic

Hay Fever No Yes _____
 Drug Allergies No Yes _____
 Other _____

Neurological

Tremors No Yes _____
 Dizzy Spells No Yes _____
 Numbness/Tingling No Yes _____
 Weakness No Yes _____
 Other _____

Endocrine

Excessive Thirst No Yes _____
 Too Hot/Cold No Yes _____
 Tired/Sluggish No Yes _____
 Change In Clothing Size No Yes _____
 Other _____

Gastrointestinal

Abdominal Pain No Yes _____
 Nausea/Vomiting No Yes _____
 Indigestion/Heartburn No Yes _____
 Diarrhea No Yes _____
 Constipation No Yes _____
 Other _____

Cardiovascular

Chest Pain No Yes _____
 Varicose Veins No Yes _____
 High Blood Pressure No Yes _____
 Other _____

Integumentary

Skin Rash No Yes _____
 Boils No Yes _____
 Persistent Itch No Yes _____
 Other _____

Musculoskeletal

Joint Pain No Yes _____
 Neck Pain No Yes _____
 Back Pain No Yes _____
 Other _____

Ear/Nose/Throat/Mouth

Ear Infection No Yes _____
 Sore Throat No Yes _____
 Sinus Problems No Yes _____
 Other _____

Genitourinary

Urine Retention No Yes _____
 Painful Urination No Yes _____
 Urinary Frequency No Yes _____
 Weak Stream No Yes _____
 Strong Urge to Void No Yes _____
 Get Up At Night To Void No Yes _____
 Other _____

Respiratory

Wheezing No Yes _____
 Frequent Cough No Yes _____
 Shortness of Breath No Yes _____
 Other _____

Hematologic

Swollen Glands No Yes _____
 Blood Clotting Problem No Yes _____
 Other _____

Psychologic

Are you generally satisfied with your life? No Yes _____
 Do you feel severely depressed? No Yes _____
 Have you considered suicide? No Yes _____
 Other _____

Physician Use Only

Physician Signature

Date