

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 _____

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 _____

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

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

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

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

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

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

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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<p>Are you on any medication? No Yes If yes, list all</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Do you have any allergies? No Yes If yes, please explain</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Are you on a special diet? No Yes If yes, please explain</p> <p>_____</p> <p>_____</p> <p>_____</p>
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List all serious illnesses in your immediate family (e.g. diabetes, tuberculosis, breast cancer, heart disease, etc)

Review of Systems

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