West Georgia Urology

PATIENT MEDICAL HISTORY FORM
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Today's Date: _____

Name:

_____
(Last) (First) (Middle Initial)

Date of Birth: ___/___/_____ **Age:** _____

Have you had any recent X-RAYS or SCANS? (CIRCLE ONE): YES or NO

Explain: _____

Reason for Visit: _____

When did symptoms start? _____ **What makes them better?**

_____

What makes them worse? _____ **Do you have fever or chills?** _____

Circle the number that best describes the problem:

Not Bad – 1 2 3 4 5 6 7 8 9 10 – Very Bad

MEDICAL HISTORY:

Do you have or have you ever had any of the following: Circle Yes (Y) or No (N)

Heart disease	Y N	Who is your heart doctor? _____
Heart attack	Y N	When? _____
High Blood Pressure	Y N	
Diabetes	Y N	
Stroke	Y N	When? _____
Asthma	Y N	
Cancer	Y N	What kind? _____

		When? _____
Kidney Stone	Y N	When? _____
Urinary/Bladder Infection	Y N	How often? _____
Thyroid Disease	Y N	
Arthritis	Y N	
Glaucoma	Y N	

Other Medical Problems (please list):_____

_____

Previous Surgery: **Circle Yes (Y) or No (N). If yes, indicate Date of Surgery.**

Heart Bypass	Y N	When? _____	Hysterectomy	Y N	When? _____
Heart Angioplasty	Y N	When? _____	Tonsils	Y N	When? _____
Heart Stent	Y N	When? _____	Ear Tubes	Y N	When? _____
Gallbladder	Y N	When? _____	Bone or Joint	Y N	When? _____
Appendix	Y N	When? _____	Hernia	Y N	When? _____
C-section	Y N	When? _____			

Other Surgeries (please list):_____

_____

FAMILY HISTORY:

Father: Living? If yes, Age: ___ Deceased? Cause of Death: _____
Age at Death:___

Mother: Living? If yes, Age: ___ Deceased? Cause of Death: _____
Age at Death:___

Has any blood relative ever had any of the following? **Circle Yes (Y) or No (N).**

Heart Disease	Y N	Kidney Stones	Y N
High Blood Pressure	Y N	Prostate Cancer	Y N
Bleeding Disorder	Y N	Ulcers	Y N

Tuberculosis	Y N	Asthma	Y N
Hepatitis	Y N	Allergies	Y N
Diabetes	Y N	Stroke	Y N
Cancer	Y N		

SOCIAL HISTORY:

Chew/Dip Tobacco	Y N	How Long? ___ yrs. When quit? _____
Smoke	Y N	__Packs/day for ___ yrs. When quit? _____
Drink Alcohol	Y N	Amount? ____ for ___yrs. When quit? _____
Use Drugs	Y N	
Female Only: Menstrual Cycle	Y N	Date of last menstrual cycle _____

SYSTEM REVIEW:

Do you have or have you recently had any of the following? **Circle Yes (Y) or No (N).**

Constitutional		**Respiratory**		**Neurologic**	
Fever	Y N	Shortness of Breath	Y N	Tingling	Y N
Chills	Y N	Wheezing	Y N	Numbness	Y N

Eyes		**GI**		**Musculosketal**	
Blurry Vision	Y N	Nausea	Y N	Bone Pain	Y N
Double Vision	Y N	Vomiting	Y N	Joint Pain	Y N
		Constipation	Y N		

HENT		**Genitourinary**		**Endocrine**	
Sore Throat	Y N	Frequency	Y N	Night Sweats	Y N
Nasal Congestion	Y N	Voiding at Night	Y N	Weakness	Y N

Cardiovascular		**Integument/Skin**		**Psychiatric**	
Chest pain	Y N	Rash	Y N	Anxiety	Y N
Shortness of Breath with activity	Y N	Itching	Y N	Depression	Y N