ADVANCED UROLOGY INSTITUTE

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ANNUAL VISIT -- PATIENT HISTORY FORM

NAME_____ TODAY'S DAY_____ DATE OF BIRTH_____

NAME OF YOUR PRIMARY CARE DOCTOR_____

CHIEF COMPLAINT/REASON OF VISIT_____

PHARMACY NAME AND LOCATION_____

ALLERGIES TO ANY MEDICATIONS, FOODS OR IV CONTRAST/X-RAY DYE_____

PLEASE COMPLETE YOUR MOST CURRENT MEDICATION LIST:

Name of Medication/Over the Counter meds/Vitamins/Herbal Meds	Strength	# of times taken per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PAST MEDICAL HISTORY

PLEASE LIST ANY NEW MEDICAL PROBLEMS OR SURGERIES YOU HAVE HAD IN THE PAST YEAR (OR SINCE YOUR LAST VISIT)

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NAME_____ TODAY'S DAY_____DATE OF BIRTH_____

SOCIAL HISTORY:
Do you smoke cigarettes? _____NO _____YES How many packs per day?_____

If NO, have you ever smoked? _____NO _____YES – When did you quit? _____

Do you drink alcohol? _____Never _____Occasional _____Daily – # of Drinks per day _____

ARE YOU: _____MARRIED _____DIVORCED _____SINGLE (NEVER MARRIED) _____WIDOWED

REVIEW OF SYSTEMS: Please check YES or NO

General/Constitutional
- Headache ( )Yes ( )No
- Chills ( )Yes ( )No
- Fever ( )Yes ( )No

Opthamologic
- Blurring of Vision ( )Yes ( )No
- Double Vision ( )Yes ( )No
- Eye Pain ( )Yes ( )No
- Glaucoma ( )Yes ( )No

HEENT/Neck
- Ear Infection ( )Yes ( )No
- Sinus Problems ( )Yes ( )No
- Sore Throat ( )Yes ( )No

Endocrine
- Excessive thirst ( )Yes ( )No
- Too hot/too cold ( )Yes ( )No
- Fatigue ( )Yes ( )No

Respiratory
- Cough ( )Yes ( )No
- Shortness of breath ( )Yes ( )No
- Wheezing ( )Yes ( )No

Cardiovascular
- Chest Pain ( )Yes ( )No
- High Blood Pressure ( )Yes ( )No
- Varicose Veins ( )Yes ( )No

Urologic
- Urinary Retention ( )Yes ( )No
- Painful Urination ( )Yes ( )No
- Urinary Frequency ( )Yes ( )No

Neurologic
- Dizziness ( )Yes ( )No
- Numbness/Tingling ( )Yes ( )No
- Tremor ( )Yes ( )No

Musculoskeletal
- Neck Pain ( )Yes ( )No
- Back Pain ( )Yes ( )No
- Joint Pain ( )Yes ( )No

Dermatologic
- Boils ( )Yes ( )No
- Itching ( )Yes ( )No
- Rash ( )Yes ( )No

Hematology
- Swollen Glands ( )Yes ( )No
- Blood Clotting problem ( )Yes ( )No

Psychiatric
- Insomnia ( )Yes ( )No
- Anxiety ( )Yes ( )No
- Depression ( )Yes ( )No

Gastrointestinal
- Abdominal Pain ( )Yes ( )No
- Heartburn/Indigestion ( )Yes ( )No
- Nausea/Vomiting ( )Yes ( )No

COMMENTS:_____