



ADVANCED UROLOGY INSTITUTE  
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

Neurologic

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

Ophthalmologic

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

Musculoskeletal

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

HEENT/Neck

- Ear Infection ( )Yes ( )No
Sinus Problems ( )Yes ( )No
Sore Throat ( )Yes ( )No

Dermatologic

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

Endocrine

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

Hematology

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

Respiratory

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

Psychiatric

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

Cardiovascular

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

Gastrointestinal

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

Urologic

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

COMMENTS: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_