Name: ________________________________

Date of Birth: ___________________________

Referring Physician: ______________________

Primary Care Physician: ___________________

MIDATLANTIC UROLOGY ASSOCIATES, LLC.

Patient History Form

Person #: _________

Chief Complaint *Check the reason(s) for your visit below. Describe:*

__ Abdominal pain __Bladder cancer __ Blood in the urine __ Difficulty with urination
__ Elevated PSA __Erectile dysfunction __ Incontinence __Infertility
__ Kidney cancer __Kidney stones __ Prostate cancer __ Prostate check
__Urinary tract infection __Vasectomy Other: __________________________

HISTORY OF PRESENT ILLNESS

Location of the problem: ___________________
When did you first notice it: ________________
How long does it last: ______________________
Is it constant or variable: ___________________
Is there any other related problem: __________________
What helps the problem: _________________________
What makes it worse: ____________________________
Rate how severe the problem is (10 is most severe):
(circle) 1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY

Have you ever been treated for any of the following medical problems?
*Circle **Y** or **N**, Also List Treating Doctor*

Adrenal Problems	Y	N
Asthma/Emphysema	Y	N
Blood Clots	Y	N
Cancer: _____________	Y	N
Cataracts	Y	N
Diabetes	Y	N
Gastrointestinal Bleed	Y	N
Glaucoma	Y	N
Gout	Y	N
Hepatitis	Y	N
Heart Attack/Stent/Bypass	Y	N
Heart Disease/Failure	Y	N
Irregular Heart Beat	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
HIV/AIDS	Y	N
Kidney Failure	Y	N
Kidney Stones	Y	N
Reflux/GERD/Irritable Bowel	Y	N
Sleep Apnea	Y	N
Stroke/Neurologic Disease	Y	N
Thyroid Disease	Y	N
Urinary Infection	Y	N

Other:_______________

PAST SURGICAL HISTORY ___ *None*

Have you ever had any type of surgery or procedure?

Surgery/Procedure	Date & Doctor
______________________	_________________
______________________	_________________
______________________	_________________
______________________	_________________

MEDICATIONS ___ *None* (You may attach a list)

List all prescription & over-the-counter medications you are taking now or have taken in the past month.

Medication	Dose & Prescribing Doctor
_________________________	______________
_________________________	______________
_________________________	______________
_________________________	______________
_________________________	______________
_________________________	______________

ALLERGIES ___ *No Allergies*

Check below if allergic to any of the following

___Penicillin ___ Sulfa ___ Latex
___ Contrast Dye ___Iodine ___Seafood

Other: _____________________

____
Physician Signature & Date

Patient Name: ____________________

Person #:

MIDATLANTIC UROLOGY ASSOCIATES, LLC.

Patient History Form

SOCIAL HISTORY *Circle **Y** or **N***

Do you currently smoke?	Y	N
Have you ever been a smoker?	Y	N
For how many years?	_____	
Packs per day	_____	
Do you drink alcohol?	Y	N
How many drinks per week?	_____	
Do you take any illegal drugs?	Y	N
Intravenous drugs?	Y	N

Occupation: _______________________

Employer: _________________________

___ Married ___ Divorced ___ Single ___ Widow

Number of Children___ Number of Pregnancies___

FAMILY HISTORY *Circle **Y** or **N***

Do you have any parents or siblings with any of the following conditions?

Prostate Cancer	Y	N
Kidney Cancer	Y	N
Other Cancers: _________________		
Kidney Stones	Y	N
Diabetes	Y	N
Heart Disease	Y	N
High Blood Pressure	Y	N
Other: ________________________		

REVIEW OF SYSTEMS Do you now have or have you recently had any problems related to the following? *Circle **Y** or **N***

GENERAL SYMPTOMS		
Fatigue	Y	N
Fever	Y	N
Night Sweats	Y	N
EYE/EAR/NOSE/THROAT		
Eyes, Discharge	Y	N
Eyes, Visual Loss	Y	N
Ears, Discharge	Y	N
Ears, Hearing Loss	Y	N
Nasal Discharge	Y	N
RESPIRATORY		
Cough	Y	N
Shortness of Breath	Y	N
Wheezing	Y	N
HEART/VASCULAR		
Chest Pain	Y	N
Palpitations	Y	N
Swollen Feet/Legs	Y	N
ENDOCRINE		
Cold Intolerance	Y	N
Heat Intolerance	Y	N
Marked Thirst	Y	N
Chronic Hunger	Y	N

GENITOURINARY		
Blood in Urine	Y	N
Frequent Urination	Y	N
Painful Urination	Y	N
Less Sexual Interest	Y	N
Penile Discharge	Y	N
GYNECOLOGY		
Painful Periods	Y	N
Heavy Periods	Y	N
Vaginal Discharge	Y	N
GASTROINTESTINAL		
Abdominal Pain	Y	N
Constipation	Y	N
Diarrhea	Y	N
Vomiting	Y	N
Heartburn	Y	N
Reflux	Y	N
Poor Appetite	Y	N

NEUROLOGY		
Unstable Gait	Y	N
Tremors	Y	N
Numbness/Tingling	Y	N
Depression	Y	N
SKIN		
Persistent Itching	Y	N
Rash	Y	N
MUSCULOSKELETAL		
Back Pain	Y	N
Joint Pain	Y	N
Neck Pain	Y	N
BLOOD/LYMPH		
Easy Bleeding	Y	N
Easy Bruising	Y	N
Blood Clots	Y	N
IMMUNOLOGY		
Environmental Allergy	Y	N
Food Allergy	Y	N

VITAL SIGNS Height: ___________ Weight: ___________

I certify that, to the best of my knowledge, the information on this form is complete and correct.

Patient Signature: ______________________

Date: ________________________________

For Office Use:

Reviewed by	Date	Reviewed by	Date
_________	_____	_________	_____
_________	_____	_________	_____

Physician Signature & Date: ____________________________________