Health History Form

Name: ____ **Date of Birth:** ___/___/___ **Age:** _________

Do you now or have you had any of the problems listed below? Circle "Y" Yes or "N" No

Constitutional	
Fever	Y N
Chills	Y N
Headache	Y N
Other	Y N
Eyes	
Blurred Vision	Y N
Glaucoma	Y N
Vision Loss	Y N
Other	Y N
Ears, Nose, Throat	
Ear Infection	Y N
Sinus Problems	Y N
Sore Throat	Y N
Other	Y N
Respiratory	
Asthma	Y N
COPD	Y N
Tuberculosis	Y N
Other	Y N
Cardiovascular	
Chest Pain	Y N
Coumadin Therapy	Y N
Hypertension	Y N
Other	Y N
Gastrointestinal	
Indigestion	Y N
Nausea/Vomiting	Y N
Stomach Pain	Y N
Other	Y N
Genitourinary	
Blood in Urine	Y N
Flank Pain	Y N
Incomplete Void	Y N
Genitourinary - Continued	
Incontinence – Stress	Y N
Incontinence – Urge	Y N
Kidney Stones	Y N
Pelvic Pain	Y N
Urinary Infection	Y N
Urinary - Dribbling	Y N
Urinary - Hesitancy	Y N
Urinary - Intermittency	Y N
Urinary – Weak Stream	Y N
Genitourinary - Female	
Cystocele	Y N
Hot Flashes	Y N
Painful Intercourse	Y N
Prolapsed Bladder	Y N
Vaginal Discharge	Y N
Other	Y N
Genitourinary - Male	
Erectile Dysfunction	Y N
Prostate Cancer	Y N
Prostate – Enlarged	Y N
Prostatitis	Y N
PSA - Abnormal	Y N
Semen - Bloody	Y N
Testicle Mass	Y N
Testicular Pain	Y N
Tight Foreskin	Y N
Vasectomy	Y N
Other	Y N
Hematological/Lymphatic	
Blood Transfusions	Y N
Clotting Problems	Y N
Hepatitis	Y N
Other	Y N
Genitourinary - STDs	
Chlamydia	Y N
Genital Herpes	Y N
Gonorrhea	Y N
HIV/AIDS	Y N
Syphilis	Y N
Venereal Warts	Y N
Other	Y N
Musculoskeletal	
Arthritis	Y N
Joint Pain	Y N
Loss of Motion	Y N
Other	Y N
Integumentary	
Nodules	Y N
Rashes	Y N
Warts	Y N
Other	Y N
Neurological	
Fainting	Y N
Migraines	Y N
Seizures	Y N
Stroke	Y N
Other	Y N
Psychiatric	
Anxiety	Y N
Depression	Y N
Insomnia	Y N
Other	Y N
Endocrine	
Diabetes	Y N
Excessive Thirst	Y N
Fatigue	Y N
Other	Y N

Physican Comments:

Physican Signature: Date:

Patient Signature: Date:

Revised: 02/20/2006

Health History Form

Past Medical History

Surgery	Date	Location	Illness	Year

Family Medical History	Father	Mother	Brother(s)	Sister(s)
Bladder Cancer	☐	☐	☐	☐
Cardiac Disease	☐	☐	☐	☐
Congenial Urological Conditions	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Kidney Cancer	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐
Renal Stone	☐	☐	☐	☐

Social History

Alcohol Use:

☐ Do not use
☐ Social Drinker
☐ Beer = Amount ______________________________
☐ Wine = Amount ______________________________
☐ Liquor = Amount ______________________________

Tobacco Use:

☐ Do not smoke
☐ Cigarettes = Number of years_______________
☐ Quit smoking = Number of years_______________
☐ Have smoker in the home
☐ Other ____

Caffeine:

☐ Do not use
☐ Coffee = _______________________ amount per day
☐ Cola = _______________________ amount per day
☐ Tea = ________________________amount per day

Marital Status:

☐ Single
☐ Married
☐ Divorced
☐ Widow(er)

Employment:

☐ Unemployed
☐ Student
☐ Child/Infant
☐ Employed _____________________________________
☐ Retired / *Occupation*

History Given By:

☐ Self
☐ Spouse
☐ Parent
☐ Caregiver
☐ Guardian/POA
☐ Medical Records

Known Allergies:

____
____
____
____
____

Patient's Signature:____ Date: ___/___/___

Revised: 02/20/2006