Health History Form

Name: ___________________________________ Date of Birth: ___/___/___ Age: _________

Do you have now or have you had in the past 6 months any of the problems listed below? Circle "Y" Yes or "N" No

Constitutional	
Fever	Y N
Chills	Y N
Fatigue/Weakness	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
Hypertension	Y N
Irregular Heartbeat	Y N
Other	Y N
Gastrointestinal	
Abdominal Pain	Y N
Indigestion	Y N
Nausea/Vomiting	Y N
Other	Y N
Genitourinary	
Bedwetting	Y N
Blood in Urine	Y N
Decreased Sex Drive	Y N
Flank Pain	Y N
Frequent Urination	Y N

Genitourinary - Continued	
Incomplete Void	Y N
Incontinence – Stress	Y N
Incontinence – Urge	Y N
Kidney Stones	Y N
Pelvic Pain	Y N
Urinary - Dribbling	Y N
Urinary - Hesitancy	Y N
Urinary - Intermittency	Y N
Urinary - Urgency	Y N
Urinary - Weak Stream	Y N
Urinary Infection	Y N
Other	Y N
Genitourinary - Female	
Cystocele	Y N
Painful Intercourse	Y N
Pregnancy	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
Foreskin Problems	Y N
Vasectomy	Y N
Other	Y N
Genitourinary - STDs	
Chlamydia	Y N
Genital Herpes	Y N
Gonorrhea	Y N

GU - STDs - Continued	
HIV/AIDS	Y N
Syphilis	Y N
Venereal Warts	Y N
Other	Y N
Hematological/Lymphatic	
Blood Transfusions	Y N
Clotting Problems	Y N
Hepatitis	Y N
Other	Y N
Musculoskeletal	
Arthritis	Y N
Back Pain	Y N
Joint Pain	Y N
Loss of Motion	Y N
Other	Y N
Integumentary	
Rashes	Y N
Skin Cancer	Y N
Warts	Y N
Other	Y N
Neurological	
Fainting	Y N
Seizures	Y N
Stroke	Y N
Other	Y N
Psychiatric	
Anxiety	Y N
Dementia	Y N
Depression	Y N
Other	Y N
Endocrine	
Abnormal Thyroid	Y N
Diabetes	Y N
Excessive Thirst	Y N
Other	Y N

Physican Comments:

Health History Form

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

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: ___/___/___

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