

STATE COLLEGE UROLOGIC ASSOCIATES, INC
MEDICAL HISTORY INFORMATION

PLEASE PRINT

DATE: _____

NAME: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

IS YOUR VISIT RELATED TO AN ACCIDENT? YES NO

If yes: TYPE OF ACCIDENT: AUTO WORKMAN'S COMP OTHER
DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____
PLACE OF ACCIDENT: _____

DID ANOTHER PHYSICIAN REFER YOU HERE? YES NO IF YES, NAME _____
REFERRING PHYSICIAN'S PHONE AND/OR ADDRESS: _____

HOW MANY CHILDREN DO YOU HAVE? _____ HAVE YOU EVER HAD A PROBLEM WITH ANESTHESIA? YES NO

MEDICATIONS (Prescribed and/or over-the-counter) YOU ARE PRESENTLY USING:
NAME OF MEDICATION DOSAGE TIMES PER DAY TAKEN

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF SO, PLEASE LIST NAME OF MEDICATION AND REACTION:

LIST ALL OPERATIONS YOU HAVE HAD WITH THE DATE PERFORMED (Year Performed)*:

LIST HOSPITALIZATIONS OTHER THAN FOR SURGERY (Year Admitted):

FAMILY HISTORY (PLEASE LIST PERTINENT ILLNESSES WITH MOTHER, FATHER, SIBLINGS, ETC.):

PLEASE CONTINUE TO PAGE 2

PATIENT INFORMATION PAGE 2

UROLOGIC HISTORY:	NO	YES	FAMILY MEMBER (if applicable)
A. HAVE YOU HAD PREVIOUS UROLOGIC INFECTIONS?	___	___	_____
B. HAVE YOU EVER HAD BLOOD IN YOUR URINE?	___	___	_____
C. DO YOU HAVE BURNING ON URINATION?	___	___	_____
D. DO YOU HAVE A PROBLEM WITH INFERTILITY?	___	___	_____
E. HAVE YOU EVER HAD A KIDNEY STONE?	___	___	_____
F. DO YOU HAVE PROBLEMS CONTROLLING YOUR URINE?	___	___	_____
G. DO YOU HAVE A WEAK STREAM?	___	___	_____
H. DO YOU HAVE TO GET UP AT NIGHT TO URINATE?	___	___	# OF TIMES _____
I. DO YOU HAVE BACK OR KIDNEY PAIN?	___	___	_____

HEART HISTORY:	NO	YES	FAMILY MEMBER (if applicable)
A. DO YOU HAVE HIGH BLOOD PRESSURE?	___	___	_____
B. DO YOU HAVE A HEART MURMUR?	___	___	_____
C. DO YOU HAVE CHEST PAIN?	___	___	_____
D. HAVE YOU HAD A HEART ATTACK? YEAR? _____	___	___	_____
E. HAVE YOU HAD HEART FAILURE?	___	___	_____
F. HAVE YOU HAD HEART SURGERY?	___	___	_____
G. DO YOU HAVE AN IRREGULAR HEART BEAT?	___	___	_____
H. DO YOU HAVE A PACEMAKER?	___	___	_____

LUNG HISTORY:	NO	YES	FAMILY MEMBER (if applicable)
A. DO YOU OFTEN COUGH UP PHLEGM?	___	___	_____
B. DO YOU HAVE ASTHMA?	___	___	_____
C. DO YOU HAVE EMPHYSEMA?	___	___	_____

DO YOU HAVE A HISTORY OF:	NO	YES	FAMILY MEMBER (if applicable)
A. BLEEDING TENDENCIES?	___	___	_____
B. BLOOD CLOTS?	___	___	_____
C. CANCER?	___	___	_____
D. DIABETES?	___	___	_____
E. HEPATITIS?	___	___	_____
F. JAUNDICE?	___	___	_____
G. THYROID DISEASE?	___	___	_____
H. SKIN PROBLEMS?	___	___	_____
I. MUSCULOSKELETAL PROBLEMS?	___	___	_____
J. GASTROINTESTINAL PROBLEMS?	___	___	_____

Describe any yes's _____

HAVE YOU EVER HAD A NEUROLOGIC DISEASE WHICH REQUIRED TREATMENT? YES NO
 Describe _____

MENSTRUAL HISTORY:
A. IS YOUR MENSES REGULAR? _____ IRREGULAR? _____ DATE OF LAST MENSES? _____
B. ARE YOU POST-MENOPAUSAL? YES NO C. NUMBER OF PREGNANCIES? _____
D. NUMBER OF NORMAL DELIVERIES? _____ E. NUMBER OF CHILDREN? _____

SOCIAL HISTORY:	YES	NO	(circle one)
A. DO YOU SMOKE?	YES	NO	# PER DAY/WEEK
B. DO YOU CONSUME ALCOHOLIC BEVERAGES?	YES	NO	# PER DAY/WEEK