HOUSTON METRO UROLOGY
Patient History Form

Name: _____ **Date of Birth:** _____ **Date:** _____

Referring Doctor: _____ **Doctor you are seeing today:** _____

Why are you seeing the doctor today?_____
How long have you had this problem?_____

ALLERGIES - Please list **ALL types: or** circle **NONE**_____
_____

PAST MEDICAL HISTORY **Please CIRCLE if you have or have had any of the following diseases or conditions:**

Cardiovascular
Anemia
Angina (Chest Pain)
Aortic Aneurysm
Arrhythmia (Irregular Heartbeat)
Atrial Fibrillation
Bleeding Disorder
Cerebrovascular Disease/Stroke
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis (Blood clots)
Heart Attack
Heart Murmur
Heart Valve Problem/Replacement
Hypertension (High Blood Pressure)
Mitral Valve Prolapse
Sickle Cell Anemia
Thrombophlebitis

Endocrine/Metabolic
Diabetes Mellitus, non-insulin dependent
Diabetes Mellitus, insulin dependent
Gout
Hyperthyroidism (High)
Hypothyroidism (Low)

General
Allergies
Hernia Location_____
Hypercholesterolemia (High cholesterol)
Malaise (Weak/Tired)
Sleep Apnea

GI
Cholelithiasis (gallstones)
Colitis
Constipation
Crohn's Disease
Diarrhea
Diverticulosis
GERD (Acid Reflux, Indigestion)
Hemorrhoids
Hepatitis
Inflammatory Bowel Disease
Peptic Ulcer
Ulcerative Colitis

GU
AIDS
Bladder Stone
Bladder Infection (UTI)
Chronic Renal Insufficiency
Erectile Dysfunction
Hematuria (blood in urine)
Interstitial Cystitis
Irradiation Therapy
Kidney Infection
Kidney Stones
Neurogenic Bladder
Orchitis (testicular infection)
Polycystic Kidney Disease
Recurrent UTI
Transplant Recipient
Uretheral Cancer
Undescended Testicle

GYN/OB
Endometriosis
Menopause
Osteoporosis
Uterine Fibroids

HEENT
Blindness
Cataracts
Glaucoma
Mumps

Musculoskeletal
Arthritis
Back Pain
Fibromyalgia

Neuro/Psych
Alcoholism
Alzheimer's disease
Anxiety
Bi-polar Disorder
Chronic Fatigue Syndrome
Depression
Epilepsy
Migraine
Multiple Sclerosis
Parkinson's
Spinal Cord Injury
Stroke
Suicide Attempt

Respiratory
Asthma
Bronchitis
Emphysema (COPD)
Pneumonia
Pulmonary Embolism
Tuberculosis (TB)

Tumors
Bladder Tumor
Brain Tumor
Breast Cancer
Cervical Cancer
Colon Cancer
Lung Cancer
Lymphoma
Melanoma
Ovarian Cancer
Prostate Cancer
Renal Cell Cancer (kidney)
Testicular Cancer

PLEASE INITIAL HERE IF YOU HAVE NO DISEASES_____PLEASE LIST ANY OTHER DISEASES OR CONDITIONS:_____

SURGICAL HISTORY **Please CIRCLE if you have any of the following surgeries & indicate the year of surgery:**

CARDIOVASCULAR	YEAR
Angioplasty	_____
Aortic Aneurysm Repair	_____
CABG	_____
Carotid Artery Surgery	_____
Heart Surgery (Stents)	_____
Heart Transplant	_____
Lymphatic Node Dissection	_____
Pacemaker Insertion	_____
Artificial Heart Valves	_____
GENERAL	
Brain Surgery	_____
Disc Surgery	_____
Lumpectomy of Breast R L	_____
Parathyroidectomy	_____
Pilonidal Cyst Incision	_____
Skin Grafting	_____
GI	
Appendectomy	_____
Bariatric Surgery (Obesity)	_____
Bowel Resection	_____
Cholecystectomy (Gall Bladder)	_____
Colon Resection	_____
Colonscopy	_____
EGD	_____
Fissurectomy	_____
Hemorrhoidectomy	_____
Illeostomy	_____
Inguinal Hernia R L	_____
Laparascopy	_____
Liver Disease	_____
Lysis Adhesions	_____
Spleenectomy	_____
Umbilical Hernia	_____
Ventral Hernia Repair	_____
GU	
Bladder Surgery	_____
Biopsy Prostate	_____
Brachytherapy(Seed Implant)	_____
Circumcision	_____

	YEAR
Cystoscopy	_____
Cystoscopy-Dilation	_____
Cystoscopy-Retrograde	_____
Cystoscopy-Stent	_____
Epidiymectomy	_____
ESWL (Shockwave Stones) R L	_____
Hernia Repair R L	_____
Hydrocelectomy R L	_____
Ileal conduit	_____
Indigo Laser Surgery	_____
Inguinal (groin) Hernia	_____
Interstim	_____
Kidney Stone	_____
Laser Ureteral - Stone Tretment R L	_____
Meatotomy	_____
Needle Biopsy Prostate	_____
Nephrectomy - (kidney removal) R L	_____
Open Nephrolithotomy (removal of stones)	_____
Orchiectomy - (testes removed) R L	_____
Orchlopexy	_____
Penile Implant/Prosthesis	_____
Penectomy	_____
Penile Surgery	_____
Pyeloplasty	_____
Radical Prostatectomy	_____
Renal Transplant	_____
Spermatocelectomy	_____
TUMT Prostate (Microwave)	_____
TUNA Prostate	_____
TURBT (Bladder Tumor)	_____
TURP prostate resection	_____
Ureteroscopy R L	_____
Variocelectomy R L	_____
Vasectomy	_____
VLAP	

	YEAR
(Laser Ablation of Prostate)	_____
GYN	
C-Section	_____
Hysterectomy Abd or Vag	_____
Oophorectomy (ovaries)	_____
Salpingectomy (tubes)	_____
Tubal Ligation	_____
Vaginectomy	_____
Vulvectomy	_____
HEENT	
Cataract Surgery R L	_____
Eye Surgery R L	_____
Facial Surgery	_____
Nasal Surgery	_____
Septoplasty	_____
Sinus Surgery	_____
Tonsil Surgery	_____
Thyroid Surgery	_____
MUSCULOSKELETAL	
Amputation	_____
Location: _____	
Arthroscopic Knee Surgery	_____
Back Surgery	_____
Carpal Tunnel Surgery R L	_____
Cervical Spine Surgery	_____
Foot Surgery R L	_____
Hand Surgery R L	_____
Hip Surgery R L	_____
Knee Surgery R L	_____
Leg Surgery R L	_____
Shoulder Surgery R L	_____
RESPIRATORY	
Lung Surgery R L	_____
SKIN	
Basal Cell Carcinoma	_____
Melanoma	_____
Squamous Cell Car	_____

Please initial here if no surgeries_____ Please indicate the dates of any other surgeries and describe:

_____

_____

FAMILY HISTORY

Please indicate which family member has/had any of the following: (Mother, Father, Siblings, Grandmother, Grandfather, Aunt, Uncle)

Arthritis_____
Kidney Cancer_____
Bedwetting_____
Kidney Disease_____
Bladder Cancer_____
Kidney Stones_____
Cancer (site unknown)_____
Leukemia_____
Crohn's Disease_____
Liver Disease_____
Depression_____

Malignant Melanoma_____
Diabetes_____
Laryngeal (throat) Cancer_____
Gout_____
Pancreatic Cancer_____
Heart Attack_____
Prostate Cancer_____
Hypertension_____
Stroke_____
Thyroid Disease_____
Tuberculosis_____

Other_____

SOCIAL HISTORY

Marital Status: Single Married Separated Divorced Widowed Life Partner Common Law Spouse
Number of Dependents (children):_____ # of each, if living with you:

___Sons___Daughters___Stepchildren___Adopted___Foster_____Parents_____Grandparents

Alcohol Consumption: None Yes Occasional/Social # of drinks per day _____
Tobacco per day: None Yes #_____Packs/day _____Cigarettes/day _____Smokeless Tobacco
If you previously smoked, when did you quit? _____ How many years smoked? _____ # of packs/day
_____

Caffeinated beverages: None Low(1-2) Moderate (3-4) Excessive (5 or more)

Women: Last Menstrual Period (date):_____Are you pregnant? Yes No Number of Pregnancies? _____
Number of Vaginal deliveries? _____ Largest infant birth weight?_____

Occupation: (please circle one that applies): None Laborer Truck Driver Tradesman Clerk Administrative
Executive Professional Part-Time Retired Other_____

Recent Foreign Travel (please circle all that apply)
None
Americas: Canada Mexico Latin America South America Other_____
World Wide: Europe Africa Middle East Asia Australia Other_____

CURRENT MEDICATIONS -Initial here if you take no medications_____

List ALL medications you are currently taking, including over the counter meds & supplements. (Attach list or write on back of sheet if necessary

Aspirin YES or NO

Drug Name	Dosage	Directions/How you take it	Drug Name

Pharmacy:_____**Pharmacy Number**_____
Pharmacy Address:_____

Review of Systems **Please Mark with an X if you have recently experienced any of the following:**

Constitutional

- ❑ Chills
- ❑ Fever
- ❑ Fatigue
- ❑ Generalized Weakness
- ❑ Hot Flashes
- ❑ Night Sweats
- ❑ Weight Loss
- ❑ Other _____

Eyes

- ❑ Blindness
- ❑ Blurred vision
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Glasses
- ❑ Worsening Eyesight
- ❑ Other _____

Allergic/Immunologic

- ❑ Drug Allergies
- ❑ Other _____

Neurological

- ❑ Disoriented
- ❑ Dizzy spells
- ❑ Headache
- ❑ Leg or arm weakness
- ❑ Memory loss
- ❑ Numbness/tingling
- ❑ Stroke
- ❑ Speech Problems
- ❑ Tremors
- ❑ Other _____

Endocrine

- ❑ Diabetes
- ❑ Excessive thirst
- ❑ Pituitary disease
- ❑ Thyroid disease
- ❑Tired/Sluggish
- ❑ Too Hot/Cold
- ❑Other _____

Gastrointestinal

- ❑ Abdominal pain
- ❑ Acid reflux
- ❑ Bloody stools
- ❑ Change in Bowel Habits
- ❑ Constipation
- ❑ Diarrhea
- ❑ Hemorrhoids
- ❑ Indigestion/heartburn
- ❑ Irregular Bowl Movements
- ❑ Nausea/vomiting
- ❑ Painful swallowing
- ❑ Rectal bleeding
- ❑ Tarry stools
- ❑ Other _____

Cardiovascular

- ❑ Chest pain/angina
- ❑ Edema
- ❑ Heart attack
- ❑ Heart failure
- ❑ Heart murmur
- ❑ High blood pressure
- ❑ Irregular heartbeat
- ❑ Mitral Valve Prolapse
- ❑ Shortness of breath
- ❑ Skipped Heart Beats
- ❑ Swelling
- ❑ Other _____

Skin

- ❑ Acne
- ❑ Boils
- ❑ Changing Moles
- ❑ Persistent Itch
- ❑ Pigment Change

- ❑ Skin Rash
- ❑ Other _____

Musculoskeletal

- ❑ Arthritis
- ❑ Back pains
- ❑ Gout
- ❑ Joint pains
- ❑ Muscle Weakness
- ❑ Neck Pain/Stiffness
- ❑ Other _____

Ears/Nose/Throat

- ❑ Dry Mouth
- ❑ Ear Infection
- ❑ Hearing Problems
- ❑ Sinus Problems
- ❑ Sore Throat
- ❑ Other _____

Genitourinary

- ❑ Back pain
- ❑ Bedwetting
- ❑ Blood in urine
- ❑ Burning on urination
- ❑ Dribbling
- ❑ Erection/Ejaculation problems
- ❑ Flank pain (back pain)
- ❑ Hematuria (Blood in urine)
- ❑ Hesitancy
- ❑ Kidney Failure
- ❑ Kidney Infections
- ❑ Kidney Stones
- ❑ Nocturia (getting up at night)
- ❑ Not Emptying
- ❑ Painful Ejaculation
- ❑ Sexually Transmitted Disease
- ❑ Stranguria
- ❑ Suprapubic Pain
- ❑ Urgency
- ❑ Urinary Frequency
- ❑ Urinary Hesitancy
- ❑ Urine Incontinence (leakage)
- ❑ Urinary Tract Infections
- ❑ Urine retention
- ❑ Urologic Cancer
- ❑ Urologic Surgery
- ❑ Vaginal Bleeding
- ❑ Vaginal Discharge/Problems
- ❑ Weak Stream
- ❑ Other

_____

Respiratory

- ❑ Asthma
- ❑ Emphysema-Bronchitis
- ❑ Frequent cough
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Other

_____

Hematologic/Lymphatic

- ❑ Bleeding problems
- ❑ Blood clotting problem
- ❑ Hepatitis
- ❑ HIV (AIDS)
- ❑ Sickle Cell
- ❑ Swollen glands
- ❑ Other _____

Psychological

- ❑ Anxious
- ❑ Depressed
- ❑ Other _____