

Foothills Urology, P.C.

Medical History Form

Today's Date: / /

Last Name	First Name	Middle Name		
Social Security # - -	Date of Birth / /	Age	Sex M F	

Chief Complaint: What is the main reason for your visit? (Describe your problem in detail):

Have you had any x-rays or other testing for this condition? If yes, where and when? _____

Have you seen another urologist for this condition? If yes, whom and when? _____

Past Medical History:

List all serious illnesses and/or injuries (Example: diabetes, tuberculosis, cancer, heart disease, etc.)

List all past surgeries and when they occurred

Are you on ANY medications? No Yes (If yes, list all, including over the counter medications and dosages)

Do you take blood thinners (Aspirin compounds, anti-inflammatories or Coumadin)?

No Yes (If yes, what, how much, how often, why)

Allergies to Medications? (please list) _____

Do you use tobacco? YES NO Type _____ How much per day? _____ How long? _____

Do you drink alcohol YES NO Type _____ How much per day? _____

Do you have a history of substance abuse? YES NO Type _____ When? _____

Patient Name _____

Date _____

List all serious illness in your immediate family and who afflicted (Example: diabetes, tuberculosis, cancer, heart disease, etc.)

Review of Systems

Do you now or have you had any problems related to the following systems? Circle YES or No. Please explain any Yes answers in the space provided.

Constitutional Symptoms				Integumentry		
Fever	Y	N		Skin Rash	Y	N
Chills	Y	N		Boils	Y	N
Headache	Y	N		Persistent itch	Y	N
Other:	Y	N		Other:	Y	N
Eyes				Musculoskeletal		
Blurred vision	Y	N		Joint pain	Y	N
Double vision	Y	N		Neck pain	Y	N
Pain	Y	N		Back pain	Y	N
Other:	Y	N		Other:	Y	N
Allergic / Immunologic				Ear / Nose / Throat		
Hay Fever	Y	N		Ear infection	Y	N
Drug allergies	Y	N		Sore throat	Y	N
Other:	Y	N		Sinus problems	Y	N
Neurological				Other:	Y	N
Tremors	Y	N		Genitourinary		
Dizzy spells	Y	N		Urine retention	Y	N
Numbness / tingling	Y	N		Painful urination	Y	N
Other:	Y	N		Urinary frequency	Y	N
Endocrine				Other:	Y	N
Excessive thirst	Y	N		Respiratory		
Too hot / cold	Y	N		Wheezing	Y	N
Tired / sluggish	Y	N		Frequent cough	Y	N
Other:	Y	N		Shortness of breath	Y	N
Gastrointestinal				Other:	Y	N
Abdominal pain	Y	N		Hematologic / Lymphatic		
Nausea / vomiting	Y	N		Swollen glands	Y	N
Indigestion / heartburn	Y	N		Blood clotting problem	Y	N
Other:	Y	N		Other:	Y	N
Cardiovascular				Psychologic		
Chest pain	Y	N		Are you generally satisfied with your life?	Y	N
Varicose veins	Y	N		Do you feel severely depressed?	Y	N
High blood pressure	Y	N		Have you considered suicide?	Y	N
Other:	Y	N		Other:	Y	N