

West Shore Urology, P.L.C.

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HISTORY FOR ADULTS

DATE _____

LEGAL NAME _____ SEX _____

DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

ALLERGIES TO MEDICATIONS: _____

ALLERGIES TO LATEX? YES NO

History of rheumatic fever? YES NO

Give a brief history of your present illness:

PAST MEDICAL HISTORY

List ANY illness requiring HOSPITALIZATION and also list OPERATIONS and approximate DATES.

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

PAIN WITH URINATION YES NO

BLOOD IN THE URINE YES NO

FEVER YES NO

BACK PAIN YES NO

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS?

CONSTITUTIONAL

CHILLS YES NO

FEVER YES NO

WEIGHT LOSS YES NO

CARDIOVASCULAR

CHEST PAIN YES NO

HEART MURMUR YES NO

PALPITATIONS YES NO

(IRREGULAR HEARTBEAT)

HEENT

BLURRED VISION YES NO

DOUBLE VISION YES NO

HEARING LOSS YES NO

SORE THROAT YES NO

HEMATOLOGIC/LYMPHATIC

EASY BLEEDING YES NO

LYMPHADENOPATHY YES NO

(SWOLLEN LYMPH NODES)

PETECHIAE (BRUISING) YES NO

RESPIRATORY

CHRONIC COUGH YES NO

DYSPNEA YES NO

(SHORTNESS OF BREATH)

KNOWN TB EXPOSURE YES NO

WHEEZING YES NO

GENITOURINARY

DYSURIA YES NO

ERECTILE DYSFUNCTION YES NO

HEMATURIA YES NO

(BLOOD IN URINE)

URINARY FREQUENCY YES NO

URINARY INCONTINENCE YES NO

URINARY RETENTION YES NO

GASTROINTESTINAL

ABDOMINAL PAIN YES NO

BLOOD IN STOOL YES NO

CONSTIPATION YES NO

DIARRHEA YES NO

HEARTBURN YES NO

LOSS OF APPETITE YES NO

NAUSEA YES NO

VOMITING YES NO

INTEGUMENTARY

CONTACT ALLERGY YES NO

HIVES YES NO

ITCHING SKIN YES NO

RASH YES NO

METABOLIC/ENDOCRINE

EXCESSIVE THIRST YES NO

FATIGUE YES NO

HOT FLASHES YES NO

MUSCULOSKELETAL

ARTHRITIS YES NO

BACK PAIN YES NO

JOINT PAIN YES NO

NECK PAIN YES NO

NEUROLOGICAL

DIFFICULTY WALKING YES NO

HEADACHE YES NO

MEMORY LOSS YES NO

SEIZURES YES NO

TREMORS YES NO

PSYCHIATRIC

ANXIETY YES NO

DEPRESSION YES NO

INSOMNIA YES NO

IMMUNOLOGIC

ASTHMA YES NO

FOOD ALLERGIES YES NO

OTHER: _____

FEMALES ONLY:

DATE OF FIRST PERIOD: _____

DATE OF LAST PERIOD: _____

NUMBER OF PREGNANCIES: _____

WHEN WAS YOUR LAST FEMALE EXAMINATION AND
PAP SMEAR OR CANCER SMEAR? _____

FREQUENT URINATION YES NO

NIGHTTIME URINATION YES NO

URGENCY OF URINATION YES NO

LOSS OF URINE WHEN COUGHING, SNEEZING OR STRAINING YES NO

FEELING OF INCOMPLETE EMPTYING YES NO

HESITANCY WHEN VOIDING YES NO

DRIBBLING OF URINE YES NO

