Arizona State Urology

Patient History Form

To prevent medical errors it is critical you complete this form completely and accurately!

First Name: _____ Last Name: _____ DOB: _____ Date: _____

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone Number: _____ Preferred Lab: _____

Height: _____ ft _____ in Weight: _____ lbs Age: _____ Occupation: _____

Race: _____ Primary Language: _____ Ethnic Group: _____

How did you hear about our practice:

☐ Referring Physician ☐ Friend ☐ Internet (which site?) _____ ☐ Insurance Company ☐ Other, How? _____

Name of Physician who referred you to this Office: _____

Current Physicians	Address	Phone #	Fax #	Specialty

CHIEF COMPLAINT *(Why do you want to see the doctor?)* _____

How long have you had this complaint? _____

MEDICATIONS *(List all **Prescription** drugs you are taking with dosage and schedule)* ☐ See Attached List

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

*List all **Non-Prescription** drugs:*

Vitamins: _____ Aspirin / Ibuprofen: _____

Other (including supplements): _____

ALLERGIES *(List all allergies to drugs or foods (i.e., sulfa, shellfish))* ☐ No Known Allergies ☐ See Attached List

_____

PATIENT HISTORY *(Do you have any of the following:)*

Asthma ---------- □ Yes □ No
Atrial Fibrilation ---------- □ Yes □ No
Cancer ---------- □ Yes □ No
Type: _____
CVA / Stroke ---------- □ Yes □ No
Depression ---------- □ Yes □ No
Diabetes ---------- □ Yes □ No
DVT ---------- □ Yes □ No
Glaucoma ---------- □ Yes □ No
Heart Disease ---------- □ Yes □ No
Hepatitis ---------- □ Yes □ No
Hyperlipidemia ---------- □ Yes □ No
Hypertension ---------- □ Yes □ No
Liver Disease ---------- □ Yes □ No
Myasthenia Gravis ---------- □ Yes □ No
Neurologic Disorder ---------- □ Yes □ No
Osteoarthritis ---------- □ Yes □ No
Peripheral Vascular Disease ---------- □ Yes □ No
Thyroid Disorder ---------- □ Yes □ No
Tuberculosis ---------- □ Yes □ No
UTI Recurrent ---------- □ Yes □ No
Vascular Disease ---------- □ Yes □ No
No Medical Problems ---------- □ Yes □ No

Other Medical Problems: _____

_____

PREVIOUS SURGERIES: □ Yes □ No If yes, please complete the below.

Type	Date	Type	Date

Previous Hospitalizations for Medical Problems: □ No □ Yes. If yes, type and date: _____

_____

FAMILY HISTORY *(Please fill out as complete as possible – # of children, status, check boxes)*

	Status (Alive/Dead)	Age	Prostate Cancer	Kidney Cancer	Bladder Cancer	Breast Cancer	Diabetes	High Blood Pressure	Heart Disease
Daughters (#)			☐	☐	☐	☐	☐	☐	☐
Sons (#)			☐	☐	☐	☐	☐	☐	☐
Father	A/D		☐	☐	☐	☐	☐	☐	☐
Mother	A/D		☐	☐	☐	☐	☐	☐	☐
Grandparent			☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐
Other Family History?:									

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Children: ☐ Yes ☐ No Boys _____ Girls _____

Exercise?. . . . . ☐ Yes ☐ No Type: _____

Current Tobacco use? . . . . ☐ Yes ☐ No Prior Tobacco use? ☐ Yes ☐ No

Alcohol use? . . . . . ☐ Yes ☐ No Current Drug use? ☐ Yes ☐ No Type: _____

Caffeine use? (Cups / Day): Coffee: _____ Tea: _____ Cola: _____

REVIEW OF SYSTEMS (Have you currently or recently had)

General
Fatigue □ Yes □ No
Fever □ Yes □ No
Weight Gain □ Yes □ No
Weight Loss □ Yes □ No

Allergy
Drug Allergies □ Yes □ No
Seasonal Allergies □ Yes □ No

Opthalmologic
Blurred Vision □ Yes □ No

ENT
Dry Mouth □ Yes □ No
Nosebleeds □ Yes □ No

Endocrine
Cold Intolerance □ Yes □ No
Excessive Sweating □ Yes □ No
Heat Intolerance □ Yes □ No

Respiratory
Shortness of Breath □ Yes □ No

Cardiovascular
Chest Pain □ Yes □ No
Edema (swelling) □ Yes □ No

Gastrointestinal
Constipation □ Yes □ No
Diarrhea □ Yes □ No
Nausea □ Yes □ No

Hematology
Bleeding Problems □ Yes □ No

Musculoskeletal
Back Pain □ Yes □ No
History of Gout □ Yes □ No

Peripheral Vascular
Blood Clots in Legs □ Yes □ No

Skin
Rashes □ Yes □ No

Neurologic
Leg or Arm Weakness □ Yes □ No
Balance Difficulty □ Yes □ No
Headaches □ Yes □ No

Psychiatric
Depressed Mood □ Yes □ No

Date of Last:
Flu Shot _____
Varicella _____
Colonoscopy _____
Dexa Scan _____

Females
Mammogram _____
Annual Pap _____

Form Completed By: _____ Date: _____