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 Addres	s:	
Pharmacy Phone Number:			Preferred Lab:		
Height:ftin	Weight:	Ibs Age:	Occupation:		
Race:	Primary	Language:	E	Ethnic Group:	
How did you hear about our	oractice:				
□ Referring Physician □ Fri		et (which site?)	Insurance	Company □ Other, How?	
Name of Physician who referred	d you to this Offic	ce:			
Current Physicians		Address	Phone #	Fax#	Specialty
CHIEF COMPLAINT (Why do y	ou want to see t	the doctor?)			
How long have you had this co	mplaint?				
MEDICATIONS (List all Prescr	intion drugs vai	ı are taking with dosage	and schedule)	□ See Attached List	
·		_			
1					
2			_ 6		
3			_ 7		
4			_ 8		
List all Non-Prescription drugs.	•				
Vitamins:			Aspirin / Ibuprofen:		
Other (including supplements)					
Tanan (manamag tappamana)	1				
ALLERGIES (List all allergies to	drugs or foods	(i.e., sulfa, shellfish))	□ No Known Allei	rgies See Attached List	
PATIENT HISTORY (Do you ha	ive any of the fol	llowing:)			
Asthma	-	Glaucoma	□ Yes □ No	Osteoarthritis	□ Yes □ No
Atrial Fibrilation		Heart Disease		Peripheral Vascular Dis	
Cancer		Hepatitis		Thyroid Disorder	
Type:		Hyperlipidemia		Tuberculosis	
CVA / Stroke □ \	es □ No	Hypertension		UTI Recurrent	
Depression N	∕es □ No	Liver Disease		Vascular Disease	
Diabetes □ \		Myasthenia Gravis	□ Yes □ No	No Medical Problems	🗆 Yes 🗆 No
DVT 🗆 🕻		Neurologic Disorder			
Other Medical Problems:					

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Daughters (#)	Туре		Date	Date		Туре			Date	
AMILY HISTORY (Please fill out as complete as possible -# of children, status, check boxes)										
AMILY HISTORY (Please fill out as complete as possible -# of children, status, check boxes)										
AMILY HISTORY (Please fill out as complete as possible -# of children, status, check boxes)										
Status	revious Hospitaliza	tions for Medical Prob	olems: □ No	□ Yes. I	fyes, type and o	date:				
Status										
Alliver/Dead)	AMILY HISTORY (F	lease fill out as compl	ete as possible –	# of children	n, status, check b	oxes)	1			
Paughters (#)			Prostate	1	Bladder	Breast	Diabetes	High Blood	Heart	
Sons (#)	-,	ve/Dead)							Diseas	
State										
	` '									
Dither Family History?:		A/D								
Diter Family History?:										
Marital Status: Single Married Widowed Divorced Children: Yes No Boys Girls										
Marrial Status: Single	ther Family History	<u>):</u>								
Marrial Status: Single	COCIAL HISTORY									
Courrent Tobacco use? Yes No		alo □ Marriod (¬ Widowod □	Divorced	Children: □ Ve	s □ No □	Pove	Cirlo		
Current Tobacco use?	iantai Status. 🗆 Sing	jie 🗆 Marrieu I	_ widowed	Divorceu	Cilidien. 🗆 1e	:5 NO	ouys	GIIIS		
Cohol use?	xercise? □ Y	es □ No Type: _								
### EVIEW OF SYSTEMS (Have you currently or recently had) General	urrent Tobacco use'	? □ Yes □ No	Prior Toba	icco use?	□ Yes □ No					
EVIEW OF SYSTEMS (Have you currently or recently had) General	Icohol use?	□ Yes □ No	Current Dr	rug use?	□ Yes □ No	Тур	e:	· · · · · · · · · · · · · · · · · · ·		
General Respiratory Skin Fatigue □ Yes □ No Shortness of Breath □ Yes □ No Rashes □ Yes Fever □ Yes □ No Cardiovascular Neurologic Weight Loss □ Yes □ No Chest Pain □ Yes □ No Leg or Arm Weakness □ Yes Allergy □ Yes □ No Balance Difficulty □ Yes	affeine use? (Cups /	Day): Coffee:	Tea:	(Cola:					
Fatigue	REVIEW OF SYSTE	VIS (Have you current	ly or recently had)						
Fever			-	•		S	kin			
Weight Gain Yes No Cardiovascular Neurologic Weight Loss Yes No Chest Pain Yes No Leg or Arm Weakness Yes Yes No Allergy Headaches Yes No Balance Difficulty Yes Yes No Drug Allergies Yes No Gastrointestinal Seasonal Allergies Yes No Constipation Yes No Psychiatric Diarrhea Yes No Depressed Mood Yes Yes No Blurred Vision Yes No Nausea Yes No Date of Last: ENT Bleeding Problems Yes No Varicella Yes No Dry Mouth Yes No Musculoskeletal Back Pain Yes No Dexa Scan Yes No Endocrine History of Gout Yes No Females Mammogram Yes No Excessive Sweating Yes No Peripheral Vascular Annual Pap Yes No	-		Shortness	of Breath	□ Yes □ No	R	ashes		Yes □ No	
Weight Loss Yes No Chest Pain Yes No Leg or Arm Weakness Yes Allergy Yes No Balance Difficulty Yes Allergy Headaches Yes Yes No Headaches Yes Yes No Gastrointestinal Yes No Depressed Mood Yes Yes No Depressed Mood Yes No Date of Last: Yes No Date of Last: Yes No Depressed Mood Yes No Depressed Mood Yes No Date of Last: Yes No Depressed Mood Yes No Date of Last: Yes No Depressed Mood Yes No Nosebleeds Yes No Varicella Yes No Nosebleeds Yes No Nosebleeds Yes No Nosebleeds Yes No Nosebleeds Yes No History of Gout Yes No Peripheral Vascular Annual Pap Yes No Nosebleeds Yes No Peripheral Vascular Annual Pap Yes No Nosebleeds Yes No Peripheral Vascular Annual Pap Yes No Yes				_						
Allergy Drug Allergies Yes No Gastrointestinal Seasonal Allergies Yes No Constipation Yes No Depressed Mood Yes Dotatric Diarrhea Yes No Depressed Mood Yes Dotate of Last: Hematology Flu Shot ENT Bleeding Problems Yes No Dexa Scan Dry Mouth Yes No Musculoskeletal Back Pain Yes No Endocrine Yes No Peripheral Vascular Annual Pap Excessive Sweating Yes No Peripheral Vascular Annual Pap Yes No Headaches Yes No Headaches Yes No Peripheral Vascular Annual Pap Yes No Headaches Yes No Headaches Yes No Peripheral Vascular Annual Pap Headaches Yes No Balance Difficulty Yes No Headaches Yes No Peripheral Vascular Annual Pap Heada	-						_			
Allergy Drug Allergies Yes No Gastrointestinal Seasonal Allergies Yes No Constipation Yes No Depressed Mood Yes Diarrhea Yes No Date of Last: Hematology Flu Shot Dry Mouth Yes No Depressed Mood Yes Dry Mouth Yes No Date of Last: Hematology Flu Shot Dry Mouth Yes No Varicella Dry Mouth Yes No Musculoskeletal Back Pain Yes No Peripheral Vascular Endocrine Yes No Mammogram Excessive Sweating Yes No Peripheral Vascular Annual Pap	Weight Loss	□ Yes □ No					•			
Drug Allergies Yes No Constipation Yes No Depressed Mood Yes Opthalmologic Nausea Yes No Date of Last: Hematology Flu Shot Flu Shot Colonoscopy Depressed Mood Yes No Nosebleeds Yes No History of Gout Yes No Nosebleeds Yes No History of Gout Yes No Nosebleeds Yes No Noseb	A III		Edema (s	welling)	□ Yes □ No	В				
Seasonal Allergies	Allergy								V N	
Diarrhea	D All	Waa Na	0 4 ! 4	4! 1		Н	eadaches		Yes □ No	
Opthalmologic Nausea Yes No Blurred Vision Yes No Date of Last: Flu Shot Flu Shot Colonoscopy Colonoscopy Dexa Scan Dexa Scan Back Pain Yes No Endocrine History of Gout Yes No Females Cold Intolerance Yes No Peripheral Vascular Annual Pap					- Vaa - Na				Yes □ No	
Blurred Vision			Constipati			P	sychiatric			
Hematology Flu Shot ENT Bleeding Problems Yes No Varicella Dry Mouth Yes No Colonoscopy Nosebleeds Yes No Musculoskeletal Dexa Scan Back Pain Yes No Yes No Endocrine History of Gout Yes No Females Cold Intolerance Yes No Mammogram Excessive Sweating Yes No Peripheral Vascular Annual Pap	Seasonal Allergies		Constipati Diarrhea		□ Yes □ No	P	sychiatric		Yes □ No Yes □ No	
Bleeding Problems	Seasonal Allergies Opthalmologic	□ Yes □ No	Constipati Diarrhea		□ Yes □ No	P D	sychiatric epressed Mo			
Dry Mouth Yes No Musculoskeletal Dexa Scan Dexa	Seasonal Allergies Opthalmologic	□ Yes □ No	Constipati Diarrhea Nausea	ion	□ Yes □ No	P D	sychiatric epressed Mo	ood ⊏	Yes □ No	
Nosebleeds Yes No Musculoskeletal Back Pain Dexa Scan	Seasonal Allergies Opthalmologic Blurred Vision	□ Yes □ No	Constipati Diarrhea Nausea Hematolo	on	□ Yes □ No □ Yes □ No	P D D F	sychiatric pepressed Mo rate of Last: lu Shot	ood 🗆	Yes □ No	
Back Pain Yes No Endocrine	Seasonal Allergies Opthalmologic Blurred Vision ENT	□ Yes □ No	Constipati Diarrhea Nausea Hematolo	on	□ Yes □ No □ Yes □ No	P D D F V	sychiatric lepressed Mo late of Last: lu Shot	ood =	Yes □ No	
Endocrine History of Gout	Seasonal Allergies Opthalmologic Blurred Vision ENT Dry Mouth	 Yes □ No Yes □ No □ Yes □ No	Constipati Diarrhea Nausea Hematolo Bleeding I	ogy Problems	□ Yes □ No □ Yes □ No	P D D F V C	sychiatric epressed Mo ate of Last: lu Shot aricella	ood =	Yes □ No	
Cold Intolerance	Seasonal Allergies Opthalmologic Blurred Vision ENT Dry Mouth	 Yes □ No Yes □ No □ Yes □ No	Constipati Diarrhea Nausea Hematolo Bleeding I	ogy Problems	□ Yes □ No □ Yes □ No	P D D F V C D	sychiatric epressed Mo ate of Last: lu Shot aricella	ood =	Yes □ No	
Excessive Sweating	Seasonal Allergies Opthalmologic Blurred Vision ENT Dry Mouth Nosebleeds	 Yes □ No Yes □ No □ Yes □ No	Constipati Diarrhea Nausea Hematolo Bleeding I Musculos Back Pain	ogy Problems	□ Yes □ No □ Yes □ No □ Yes □ No	P D F V C	sychiatric lepressed Mo late of Last: lu Shot laricella lolonoscopy lexa Scan	ood =	Yes □ No	
	Seasonal Allergies Opthalmologic Blurred Vision ENT Dry Mouth Nosebleeds Endocrine	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No	Constipati Diarrhea Nausea Hematolo Bleeding I Musculos Back Pain	ogy Problems	□ Yes □ No □ Yes □ No □ Yes □ No	P D D F V C D	sychiatric lepressed Mo late of Last: lu Shot laricella lolonoscopy lexa Scan emales	ood =	Yes □ No	
Heat Intolerance □ Yes □ No Blood Clots in Legs □ Yes □ No	Seasonal Allergies Opthalmologic Blurred Vision ENT Dry Mouth Nosebleeds Endocrine Cold Intolerance	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No	Constipati Diarrhea Nausea Hematolo Bleeding I Musculos Back Pain History of	Pgy Problems skeletal Gout	□ Yes □ No	P D D F V C D D F M	sychiatric lepressed Mo late of Last: lu Shot laricella lolonoscopy lexa Scan lemales lammogram	ood =	Yes □ No	
	Seasonal Allergies Opthalmologic Blurred Vision ENT Dry Mouth Nosebleeds Endocrine Cold Intolerance	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No	Constipation Diarrhea Nausea Hematolo Bleeding I Musculos Back Pain History of	ogy Problems skeletal Gout	□ Yes □ No	P D F V C D	sychiatric lepressed Mo late of Last: lu Shot laricella lolonoscopy lexa Scan lemales lammogram	ood =	Yes 🗆 N	

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