Alabama Urology Associates, P.C.

Patient History Form **Date:** ______________________

Name: ______________________ **Date of Birth:** ______________________

The Name of your Primary Care Physician: ______________________

Name the Physician that referred you if different: ______________________

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

____

____

Physician use only: (Comments/Notes)

List names of all medicines you take including any supplements or over-the-counter drugs:
(Please note: If you already have a list of your medications we can make a copy.)

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

Allergies – Please check if you are allergic to any of the following:

☐ Aspirin ☐ Demerol ☐ IVP Dye ☐ Levaquin ☐ Macrodantin ☐ Percocet ☐ Sulfa
☐ Cipro ☐ Erythromycin ☐ Keflex ☐ Lortab ☐ Morphine ☐ Phenergan
☐ Codeine ☐ Iodine ☐ Latex ☐ Macrobid ☐ Penicillin ☐ Seafood
☐ Other: ______________________

Your Medical History – Please check if you have or ever had any of the following diseases:

☐ Asthma
☐ Acid Reflux (GERD)
☐ Blood Disorder
☐ Cancer
☐ Chest Pain
☐ Dementia
☐ Depression
☐ Diabetes: How is it controlled? Diet or Insulin
☐ Endometriosis
☐ Gallbladder Disease
☐ Heart Attack
☐ Heart Failure
☐ High Blood Pressure
☐ Irregular Heartbeats
☐ Lung Disease/Emphysema
☐ Mitral Valve Prolapse
☐ Nodular Prostate w/ Urinary Obstruction
☐ Prior Chemotherapy
☐ Prior Radiation Treatment
☐ Prostate Nodule
☐ Spastic Colon
☐ Stroke
☐ Thyroid Disorder: Hyper or Hypo
☐ Tuberculosis
☐ Ulcer
☐ Other ______________
☐ Other ______________

*****Please complete the front and back of this form*****

Your Surgical History – Please check if you have had any of the following Surgeries:
(Please put the year you had your surgery in the blank provided)

Surgery	Year(s)	Surgery	Year(s)
☐ Abdominal Aneurysm	______	☐ Hernia (Left)	______
☐ Abdominal Hernia	______	☐ Hernia (Right)	______
☐ Abdominal Hysterectomy	______	☐ Joint Surgery	______
☐ Angioplasty	______	☐ Kidney Stone	______
☐ Appendectomy	______	☐ Ovary	______
☐ Back Surgery	______	☐ Pacemaker	______
☐ Bladder Surgery	______	☐ Prostate	______
☐ Breast Surgery	______	☐ Splenectomy	______
☐ C – Section	______	☐ Stomach Ulcer	______
☐ Cataracts	______	☐ Tonsils	______
☐ Cervical Disc	______	☐ Tubal Ligation	______
☐ Colon	______	☐ Vaginal Delivery	______
☐ Defibrillator	______	☐ Vaginal Hysterectomy	______
☐ Gallbladder	______	☐ Other : ______	______
☐ Heart By Pass	______	☐ Other : ______	______
☐ Heart Valve	______	☐ Other : ______	______

Your Family History – Please check if your Mother, Father, Brother, or Sister ever had any of the following diseases:
(Please list the family member in the space provided)

☐ Bladder Cancer: ______ ☐ Kidney Cancer: ______ ☐ Prostate Cancer: ______
☐ Kidney Disease: ______ ☐ Heart Disease: ______ ☐ Kidney Stones: ______
☐ High Blood Pressure: ______ ☐ Diabetes: ______ ☐ Other: ______

Your Social History:

☐ Divorced ☐ Alcohol Use: Yes or No ______ average drinks per week
☐ Married ☐ Tobacco Use: Yes or No ______ packs per day for ______ years
☐ Single

Do you have the following symptoms or diseases?
(Please check yes or no)

Fever	Yes ______	No ______	Rash	Yes ______	No ______
Chills	Yes ______	No ______	New Skin Lesions	Yes ______	No ______
Double Vision	Yes ______	No ______	Memory Difficulties	Yes ______	No ______
Cataracts	Yes ______	No ______	Headaches	Yes ______	No ______
Hearing Loss	Yes ______	No ______	Mini Strokes	Yes ______	No ______
Headaches	Yes ______	No ______	Seizures	Yes ______	No ______
Chest Pain at Rest	Yes ______	No ______	Muscle Weakness	Yes ______	No ______
Chest Pain with Exercise	Yes ______	No ______	Joint Pain	Yes ______	No ______
Irregular Heart Beats	Yes ______	No ______	Hot Flashes	Yes ______	No ______
Palpitations	Yes ______	No ______	Thyroid Disorder	Yes ______	No ______
Leg Cramps with Exercise	Yes ______	No ______	Depression	Yes ______	No ______
Shortness of Breath	Yes ______	No ______	Schizophrenia	Yes ______	No ______
Wheezing	Yes ______	No ______	Bipolar Disorder	Yes ______	No ______
Sleep Apnea	Yes ______	No ______	Easy Bleeding	Yes ______	No ______
Heartburn or Indigestion	Yes ______	No ______	Easy Bruising	Yes ______	No ______
Nausea or Vomiting	Yes ______	No ______	Sickle cell Disease or Trait	Yes ______	No ______
Change in Abdominal Girth	Yes ______	No ______	Lymph Node Enlargement	Yes ______	No ______
Diarrhea	Yes ______	No ______	Immune Deficiency	Yes ______	No ______
Constipation	Yes ______	No ______	HIV	Yes ______	No ______
Blood in Stool	Yes ______	No ______	Hepatitis C	Yes ______	No ______