# ABBEVILLE UROLOGY
## PATIENT HISTORY FORM

ACCOUNT NUMBER: _____

☐ New Patient ☐ New Problem

This is a confidential document. Please fill out completely.

Name _____
Last First MI

DATE ___/___/___ DOB ___/___/___ AGE _____ SEX M F

Who is your Primary Care Physician? _____

Who referred you to our practice? _____

In detail, please describe the main reason for your visit today. _____

_____

Where is the problem located?
☐ Front ☐ Side
☐ Back ☐ Genitilia
☐ Other _____

How long has the problem existed?
☐ 1-2 Days ☐ One Month
☐ 2 Weeks ☐ Over One Year
☐ Other _____

Does anything help ease the problem?
☐ Sitting/Standing ☐ Lying Down
☐ Pressure ☐ Hot/Cold Packs
☐ Other _____

Are there other symptoms associated with this problem?
☐ Fever/Chills ☐ Nause/Vomiting
☐ Headache ☐ Difficult Urination
☐ Other _____

Does this problem affect your daily lifestyle? ☐ Yes ☐ No
If yes, please describe _____

Circle the number that best describes your problem.

Severe 10 9 8 7 6 5 4 3 2 1 Tolerable

Have you experienced in the last 6 months any of the following? (Please check all that apply.)

- ☐ Frequent Headache
- ☐ Fever/Chills
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Depression
- ☐ Anxiety
- ☐ Overly Stressed
- ☐ Cataract
- ☐ Glaucoma
- ☐ Blurred/Double Vision
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Uncontrolled Loss of Urine
- ☐ Swolen Glands
- ☐ Easy Bleeder
- ☐ Swollen Lymph Nodes
- ☐ Ear Infection
- ☐ Bleeding Gums
- ☐ Sore Throat
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Drug Allergies
- ☐ Seasonal Allergies
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Skin Rash
- ☐ Skin Lesions
- ☐ Excessive Thirst
- ☐ Feeling of Being Tired
- ☐ Shortness of Breath
- ☐ Trouble Breathing
- ☐ Dizzy Spells
- ☐ Numbness/Tingling
- ☐ I have not experienced any of the above

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**PATIENT NAME:** _____ **ACCOUNT NUMBER** _____

Do you have any drug allergies? ❑ Yes ❑ No

If yes, please list _____

_____

Do you take any medication? ❑ Yes ❑ No

If yes, please list medicine, dosage, and reason for taking _____

_____

Have you ever undergone a surgical procedure?

❑ Yes ❑ No

If yes, please list procedure and year performed.

1. _____

2. _____

Myself/My Family has a history of.... (Please check all that apply)

| | Myself | Family | Please specify Relationship |
|---|---|---|---|
| Cancer | ❑ | ❑ | _____ |
| Heart Disease | ❑ | ❑ | _____ |
| Diabetes | ❑ | ❑ | _____ |
| High Blood Pressure | ❑ | ❑ | _____ |
| Kidney Disease | ❑ | ❑ | _____ |
| Stroke | ❑ | ❑ | _____ |
| Stomach Ulcers | ❑ | ❑ | _____ |
| Seizures | ❑ | ❑ | _____ |
| Sickle Cell Anemia/Anemia | ❑ | ❑ | _____ |
| Other _____ | ❑ | ❑ | _____ |

What is your Marital status? ❑ Single ❑ Divorced ❑ Married ❑ Widow

What is your occupation? _____ Number of children? _____

Do you smoke? ❑ Yes ❑ No

If yes, # of packs a day? ❑ Less than one ❑ Two ❑ One ❑ Three or more

Do you drink alcohol? ❑ Yes ❑ No

If yes, how much? ❑ Social ❑ Moderate ❑ Light ❑ Excessive

**FEMALE PATIENTS ONLY**

Do you have menstrual periods? ❑ Yes ❑ No

If yes, are they regular? ❑ Yes ❑ No

When was your last menstrual period: _____ / _____ / _____

Is there a chance you may be pregnant? ❑ Yes ❑ No

**PHYSICIAN NOTES**

**OFFICE USE ONLY**

Pt. Update _____ / _____ / _____

❑ Changes Made

❑ No Changes Made

Pt. Initials _____

Patient Signature _____

Physician Signature _____