UROLOGY ASSOCIATES OF IDAHO FALLS

PATIENT UROLOGIC HISTORY FORM

PATIENT DEMOGRAPHICS

DEMOGRAPHICS

Patient's Name: _____ **Date:** _____

DOB: ___/___/___ **Gender:** ◯ Male ◯ Female ◯ Other **Height:** _____ **Weight:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____

Main Phone #: _____ **Alternate #:** _____ **Work #:** _____

Marital Status: ◯ Single ◯ Married ◯ Other: _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Primary Provider: _____ **Referring Provider:** _____

Pharmacy: _____ **Home Health/Care Facility:** _____

Do you have an Advance Directive? ◯ Yes ◯ No

Type: ◯ Living will ◯ Medical durable power of attorney ◯ Other: _____

OTHER INFORMATION

Which racial category do you most closely identify with?

◯ Caucasian ◯ African American ◯ American Indian/Alaska Native ◯ Asian ◯ Other: _____

Ethnicity: ◯ Not Hispanic or Latino ◯ Hispanic or Latino

What is your language preference? ◯ English ◯ Spanish ◯ Other: _____

INSURANCE

Primary Insurance: _____ Policy/ID #: _____ Group #: _____

Name of Policy Holder: _____ DOB: ___/___/___ Employer: _____

Secondary Insurance: _____ Policy/ID #: _____ Group #: _____

Name of Policy Holder: _____ DOB: ___/___/___ Employer: _____

RESPONSIBLE PARTY

Parent/Responsible Party Name: _____ DOB: ___/___/___

Relationship: _____ City: _____ State: _____ Zip: _____

Main Contact#: _____ Alternate #: _____ Work #: _____

RELEASE OF INFORMATION

Do you want reminder calls for future appointments? ◯ Yes ◯ No

Do you want access to your electronic medical record through Patient Portal? ◯ Yes ◯ No

I, _____, hereby authorize Urology Associates of Idaho Falls to disclose my protected health information to persons/organization listed below:

Name: _____ Name: _____

Relationship: _____ Phone #: _____ Relationship: _____ Phone #: _____

This release will remain in effect until we receive written notification from you.

Signature of Patient or Guardian: _____ Date: _____

MEDICAL HISTORY FORM - Continued

MEDICATION AND ALLERGIES

Blood Thinners: ○ None
○ Aleve ○ Aspirin ○ Celebrex ○ Coumadin ○ Eliquis ○ Heparin ○ Ibuprofen
○ Lovenox ○ Mobic ○ Motrin ○ Pradaxa ○ Plavix ○ Warfarin ○ Xarelto

Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____

Medication Allergies: ○ Negative

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Are you allergic to Latex? ○ Yes ○ No
Are you allergic to Iodine? ○ Yes ○ No

MEDICAL HISTORY

Symptoms/Disease	Self	Father	Mother	Brother	Sister	Grandfather	Grandmother
Asthma	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○
Gout	○	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○	○
High Blood Pressure	○	○	○	○	○	○	○
Lung Disease	○	○	○	○	○	○	○
Kidney Failure/Disease	○	○	○	○	○	○	○
Kidney Stone	○	○	○	○	○	○	○
Prostate Issues	○	○	○	○	○	○	○
Thyroid Disease	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○
Bladder Cancer	○	○	○	○	○	○	○
Kidney Cancer	○	○	○	○	○	○	○
Ovarian Cancer	○	○	○	○	○	○	○
Prostate Cancer	○	○	○	○	○	○	○
Skin Cancer	○	○	○	○	○	○	○
Testicular Cancer	○	○	○	○	○	○	○
STD's	○						
HIV/AIDS or Hepatitis	○						

Father's Age: _____ ○ Living ○ Deceased Cause of Death (if applicable) _____
Mother's Age: _____ ○ Living ○ Deceased Cause of Death (if applicable) _____

MEDICAL HISTORY FORM - Continued

SURGICAL HISTORY

Past and Present Surgical History:

Surgery: _____ Date: _____ Physician: _____

Surgery: _____ Date: _____ Physician: _____

Surgery: _____ Date: _____ Physician: _____

Surgery: _____ Date: _____ Physician: _____

Surgery: _____ Date: _____ Physician: _____

Surgery: _____ Date: _____ Physician: _____

Surgery: _____ Date: _____ Physician: _____

SOCIAL HISTORY

Tobacco History:

Do you use tobacco product? ◯ Yes ◯ No What type: _____

Are you a former smoker? ◯ Yes ◯ No

If yes, I smoked an average of _____ packs/day for_____ years. I quit in _____(year)

Alcohol or Drug History:

Do you consume alcohol? ◯ Yes ◯ No How often: _____ Drinks per ◯ Day ◯ Week ◯ Month

Recreational drug use: ◯ Yes ◯ No What type: _____

Caffeine:

Do you drink Caffeine? ◯ Yes ◯ No How often: _____ Drinks per ◯ Day ◯ Week ◯ Month

Please complete the back of this sheet.

MEDICAL HISTORY FORM

REVIEW OF SYSTEMS

Reason for Visit: _____

_____

Review of Systems

Please mark yes to any symptoms you are currently experiencing or have recently experienced

Constitutional	○ **Negative**	**Yes**
Weight Gain		○
Weight Loss		○
Fever		○
Fatigue		○
Chills		○
Night Sweats		○
Hot Flashes		○
Ears, Nose, Throat	○ **Negative**	**Yes**
Nosebleeds		○
Hearing Loss		○
Hoarseness		○
Sore Throat		○
Difficulty Swallowing		○
Respiratory	○ **Negative**	**Yes**
Shortness of Breath		○
Asthma		○
Productive Cough		○
Wheezing		○
Cardiovascular	○ **Negative**	**Yes**
Chest Pain/Tightness		○
Irregular Rapid Heart Beat		○
Palpitations		○
GI (Gastrointestinal)	○ **Negative**	**Yes**
Black/Bloody Stools		○
Abdominal Pain		○
Nausea/Vomiting		○
Constipation		○
Loss of Appetite		○
Use of Laxatives		○
Diarrhea		○
GU (Genitourinary)	○ **Negative**	**Yes**
Frequent Urination		○
Urinary Urgency		○
Nocturia (waking up to urinate)		○
Dysuria (painful/difficult urination)		○
Hematuria (blood in urine)		○
Testicular Pain		○
Pelvic Pain		○
Abnormal Urine Smell/Color		○
Abnormal Menstruation		○
Burning (with urination)		○
Menopause		○
Pain During Intercourse		○
Weak Urinary Stream		○
Urinary Retention		○
Proteinuria (protein in urine)		○
Incontinence		○

Eyes	○ **Negative**	**Yes**
Vision Disturbance		○
Musculoskeletal	○ **Negative**	**Yes**
Back or Flank Pain		○
Neck Pain		○
Joint Swelling/Stiffness/Pain		○
Extremity Pain		○
Decreased Range of Motion		○
Unable to Bear Weight		○
Neurological	○ **Negative**	**Yes**
Numbness or Tingling		○
Headaches		○
Loss of Balance		○
Trouble with Speech		○
Forgetfulness/Confusion		○
Syncope (fainting)		○
Weakness		○
Dizziness		○
Seizures		○
Skin	○ **Negative**	**Yes**
Rash		○
Lesions		○
Breast Pain/Lump/Discharge		○
Psych/Social	○ **Negative**	**Yes**
Depression		○
Suicidal Ideations		○
Hematologic/Lymph Skin	○ **Negative**	**Yes**
Bleeding Easily		○
Swollen Glands		○
Delayed Healing		○
Bruising		○
Endocrine	○ **Negative**	**Yes**
Increased Appetite		○
Heat or Cold Intolerance		○
Increased Thirst		○
Allergy/Immunologic	○ **Negative**	**Yes**
Food Allergy		○
Environmental Allergy		○
Medication Allergy		○
Immune Disorder		○