Northwest Columbus Urology, Inc.
Medical History Form

Date Completed: ____/_____/_____

Name: _____ **Age:** _____ **DOB:** ____/_____/_____

Chief Complaint: Please list the reasons for seeing the doctor. Be as specific as you can. **Is this a yearly screening visit?** Yes or No

_____

History of Present Illness (Please answer the following questions.)

Location of problem: Abdomen Back Pelvis/Groin Genitals

Type of problem: Burning Swelling Itching Pain (Dull Ache Sharp/Stabbing Constant)

On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem:

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem and how long does it last? _____

Does anything help your symptoms? _____

Medications: List all medicines you are taking and the dosage, including 'over the counter' and supplements:

_____

_____

_____

What pharmacy do you use? Please provide their name, address & phone number.

Local: _____ Mail Order: _____

Allergies: Please list any allergies or reactions to medications, x-ray dye, tape adhesive and latex

_____

Surgery: Please list any surgical/anesthetic procedures and approximate date

_____ _____

_____ _____

Family History: Does anyone in your family (parents, siblings, children) have the following? If yes, list family member(s).

Adopted (History Unk.) _____ Cause of Death? When?

Diabetes: Yes_____ No_____ _____

Heart Disease: Yes_____ No_____ _____

Kidney Disease: Yes_____ No_____ _____

Prostate Cancer: Yes_____ No_____ _____

Cancer: Yes_____ No_____ _____

Type of Cancer: _____

Other Significant Problems: _____

Physician Use Only

Name: _____ **DOB:** ____/_____/_____

Review of Systems Do you now or have you ever had any of the following problems? Circle **Y**es or **N**o

Constitutional			**Cardiovascular/Peripheral Vascular**			**Metabolic/Endocrine**		
Fever	Y	N	Chest Pain	Y	N	Diabetes	Y	N
Chills	Y	N	Heart Murmur	Y	N	Thyroad Disease	Y	N
Weight Loss	Y	N	Irregular Heart Beat	Y	N	Fatigue	Y	N
			Heart Attack	Y	N	Hot Flashes	Y	N
HEENT			High Blood Pressure	Y	N	Gynecomastia	Y	N
Blurred Vision	Y	N	Valve Problems	Y	N	Ever Taken Steroids	Y	N
Double Vision	Y	N	Varicose Veins	Y	N			
Ear Infection	Y	N	Blood Clots	Y	N	**Neurological**		
Eye Pain	Y	N	Leg Pain When Walking	Y	N	Stroke	Y	N
Hearing Loss	Y	N				Migraines	Y	N
Sinus Infection	Y	N	**Gastrointestinal**			Seizures	Y	N
Sore Throat	Y	N	Abdominal Pain	Y	N	Headache	Y	N
Nose Bleeds	Y	N	Blood in Stool	Y	N	Tremors	Y	N
			Constipation	Y	N	Parkinsons	Y	N
Respiratory			Diarrhea	Y	N	Multiple Sclerosis	Y	N
Chronic Cough	Y	N	Heartburn	Y	N			
Shortness of breath	Y	N	Nausea & Vomiting	Y	N	**Genitourinary**		
Bronchitis	Y	N	Irritable Bowel	Y	N	Pain While Urinating	Y	N
Asthma	Y	N	Loss of Appetite	Y	N	Decreased Stream	Y	N
Emphysema	Y	N				Urinary Frequency	Y	N
Wheezing	Y	N	**Muscular/Skeletal**			Urinary Incontinence	Y	N
Known TB exposure	Y	N	Back Pain	Y	N	Urinary Retention	Y	N
			Arthritis	Y	N	Urinary Hesitancy	Y	N
Dermatology			Gout	Y	N	Blood in Urine	Y	N
Rashes	Y	N	Osteoporosis	Y	N	Sexual Dysfuntion	Y	N
Eczema	Y	N	Artificial Joints	Y	N	Lumps or Masses	Y	N
Psoriasis	Y	N						
Shingles	Y	N	**Infection**			**Blood/Oncology**		
			Rheumatic Fever	Y	N	Cancer Type _____	Y	N
Psychiatric/Sleep			Mononucleosis	Y	N	Anemia	Y	N
Anxiety	Y	N	Tuberculosis	Y	N	Bleeding Problems	Y	N
Depression	Y	N	Herpes	Y	N	Sickle Cell Disease	Y	N
Insomnia	Y	N	History of STDs	Y	N	Blood Transfusion	Y	N
Sleep Apnea	Y	N						
Do you use a C-Pap?	Y	N						

What are the settings? _____

Tobacco Do you use tobacco products? Cigarettes Y N Chewing Tobacco/Snuff Y N

Cigars Y N Pipes Y N

If yes, for how long and how much do you use per day? _____

If you used to use tobacco, when did you quit and how? _____

Alcohol Do you use alcohol? Y N What type and how much? _____

Caffeine Do you drink coffee, soda pop or energy drinks? Y N How much per day? _____

Gynecologic # of pregnancies _____ # of children _____ Last menstrual period? ____/____/____