North Carolina Urological Associates, Inc.
Patient History Form

Note:This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date_____ Date of Last Physical Exam _____ Referring MD _____ Family MD _____

Last Name _____ First Name _____ Middle _____

Social Security Number _____ Date of Birth _____Age_____

Chief Complaint - What is the main reason for your visit today? _____

_____

_____

History of Present Illness

Please answer the following questions

Location of the problem
Abdomen Back Groin
Other _____
_____
_____

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?
2 Days Ago 2 Weeks Ago 1 Month Ago

Does anything help or make the problem worse?
Moving around Standing up Lying on my side Urinating
Bowel Movement Other _____

Does anything make it less severe or go away? Moving, Position
Urinating Other _____

Have the symptoms changed over time?
No Yes If yes, please explain _____

How long does the problem last?
30 Minutes 1 Hour It is always there
Other _____

Is anything also occurring at the same time?
No Yes If yes, please explain.
Nausea Rash Headache
Other _____

Is the problem constant? Yes No
If not, describe _____
Dull then sharp Very sharp then leaves Always there
Other _____

Does the problem interfere with your normal functions? No Yes
If yes, please explain _____

Physician Use Only

Past Medical, Social History, Family History

List any personal past illness and/or surgeries and when they occurred.

Illness/Surgery	Date	Illness/Surgery	Date

Do you smoke? No Yes If yes, how much? _____

Do you drink? No Yes If yes, how much? _____

Marital Status_____ Children _____ Type of Work (describe activity level) _____

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Patient History Form, Page 2

Last Name _____ First Name _____ Middle _____

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Are you on any medication? No Yes If yes, list all	Do you have any allergies? No Yes If yes, please explain	Are you on a special diet? No Yes If yes, please explain
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all serious illnesses in your immediate family (e.g. diabetes, tuberculosis, breast cancer, heart disease, etc)

_____

_____

Review of Symptoms

Constitutional Symptoms
Fever No Yes_____
Chills No Yes_____
Headache No Yes_____
Other _____

Eyes
Blurred Vision No Yes_____
Double Vision No Yes_____
Pain No Yes_____
Other _____

Allergic/Immunologic
Hay Fever No Yes_____
Drug Allergies No Yes_____
Other _____

Neurological
Tremors No Yes_____
Dizzy Spells No Yes_____
Numbness/Tingling No Yes_____
Weakness No Yes_____
Other _____

Endocrine
Excessive Thirst No Yes _____
Too Hot/Cold No Yes _____
Tired/Sluggish No Yes _____
Change In Clothing Size No Yes_____
Other _____

Gastrointestinal
Abdominal Pain No Yes _____
Nausea/Vomiting No Yes _____
Indigestion/Heartburn No Yes _____
Diarrhea No Yes _____
Constipation No Yes _____
Other _____

Cardiovascular
Chest Pain No Yes _____
Varicose Veins No Yes _____
High Blood Pressure No Yes _____
Other _____

Integumentary
Skin Rash No Yes _____
Boils No Yes _____
Persistent Itch No Yes _____
Other _____

Musculoskeletal
Joint Pain No Yes _____
Neck Pain No Yes _____
Back Pain No Yes _____
Other _____

Ear/Nose/Throat/Mouth
Ear Infection No Yes _____
Sore Throat No Yes _____
Sinus Problems No Yes _____
Other _____

Genitourinary
Urine Retention No Yes _____
Painful Urination No Yes _____
Urinary Frequency No Yes _____
Weak Stream No Yes _____
Strong Urge to Void No Yes _____
Get Up At Night To Void No Yes _____
Other _____

Respiratory
Wheezing No Yes _____
Frequent Cough No Yes _____
Shortness of Breath No Yes _____
Other _____

Hematologic
Swollen Glands No Yes _____
Blood Clotting Problem No Yes _____
Other _____

Psychologic
Are you generally satisified with your life? No Yes _____
Do you feel severly depressed? No Yes _____
Have you considered suicide? No Yes _____
Other _____

Physician Use Only

Physician Signature Date