

DATE: _____

PENSACOLA UROLOGY PATIENT MEDICAL HISTORY

PATIENT'S NAME: _____ DOB: ____/____/____

Age: ____ Weight: ____ BP: ____ Drug Allergies: _____

Temp: ____ Pulse: _____

CHIEF COMPLAINT: _____

PAST MEDICAL & SOCIAL HISTORY

Glaucoma Yes No
 High Cholesterol Yes No
 Diabetes Yes No
 Thyroid Problems Yes No
 High Blood Pressure Yes No
 Cancer [Type_____] Yes No
 Stroke Yes No
 Heart Attack (MI) Yes No

[Date of MI_____]

Arthritis/Gout Yes No
 Epilepsy Yes No
 Hepatitis Yes No
 Venereal Disease Yes No
 Other: _____

Previous Surgeries _____

Tobacco usage Yes No Amt. _____
 Alcohol usage Yes No Amt. _____
 Drug usage Yes No Amt. _____
 Occupation: _____

Marital Status: Single Married Divorced Widowed

Family diseases: Diabetes Kidney Stones Prostate Cancer High Blood Pressure

Other _____

REVIEW OF SYSTEMS

Do you now or have you recently had any problems related to the following systems?

Constitutional Symptoms

Fever Yes No
 Chills Yes No
 Wt Loss Yes No
 Appetite Loss Yes No

Respiratory

Wheezing Yes No
 Short of Breath Yes No
 Cough Yes No
 (Productive)

Cardiovascular

Chest Pain Yes No
 Leg Pain Yes No
 (Walking)

Endocrine

Excessive Thirst Yes No
 Chills Yes No
 Tiredness Yes No

Gastrointestinal

Abdominal Pain Yes No
 Nausea/Vomiting Yes No
 Constipation Yes No
 Diarrhea Yes No

Musculoskeletal

Joint Pain Yes No
 Back Pain Yes No
Skin
 Rash/itch Yes No

GYN


Last normal menses _____
 Vaginal discharge Yes No
 Endometriosis Yes No
 Have you ever been Pregnant? Yes No

Genitourinary

Pain Urinating Yes No
 Blood in Urine Yes No
 Leaking urine Yes No
 Prostate Problems Yes No

Psychological

Depression Yes No

PLEASE COMPLETE BACK 

DATE PHYSICIAN REVIEWED AND/OR AMENDED FORM:

1.	4.	7.
2.	5.	8.
3.	6.	9.

