NORCAL UROLOGY MEDICAL GROUP

PATIENT HISTORY FORM

DATE ____/____/____ REFERRING DOCTOR ____________________

NAME____________________ PRIMARY CARE DOCTOR ____________________

REASON FOR VISIT____

MEDICATIONS

Please list all current medications, including vitamins:

Name of medication	Dose	Frequency

ALLERGIES

Please list all drug allergies:

Drug	Reaction

PAST MEDICAL HISTORY

Please check whether you have or have had any of the following conditions:

Condition			Condition		
Diabetes	☐ Yes	☐ No	High cholesterol	☐ Yes	☐ No
High blood pressure/Hypertension	☐ Yes	☐ No	COPD/emphysema	☐ Yes	☐ No
Coronary artery disease	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Chronic renal failure	☐ Yes	☐ No	Dementia (e.g., Alzheimer's)	☐ Yes	☐ No
Atrial fibrillation	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No
Type ____________			Hepatitis C	☐ Yes	☐ No
Type ____________			HIV	☐ Yes	☐ No

Others:

PAST SURGICAL HISTORY

Please list all prior surgeries:

Surgery	Year	Surgery	Year

SEE ATTACHED ☐

Reviewed by MD & discussed with patient _____

FAMILY HISTORY			
Please answer the following questions about your family members:			
Father	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Mother	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems:		
Sister	Please list any significant medical problems (if any):		
Brother	Please list any significant medical problems (if any):		
Family h/o	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)		
Specific questions for your specialty:			
Specific questions for your specialty:			

SOCIAL HISTORY		
Drinks Alcohol	Do you drink alcohol? ☐ Yes ☐ No If yes how often? Daily - Weekly - Monthly - Socially - Rarely	
	☐ Beer ☐ Wine ☐ Liquor Amount? When was your last drink?	
Tobacco Use	Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?	
	How many years did you smoke?	What year did you quit?
Drug Use	Do you currently use recreational drugs? ☐ Yes ☐ No Have you in the past? ☐ Yes ☐ No	
	Have you every used intravenous drugs? ☐ Yes ☐ No	
Caffeine Use	If yes, what kind? Please circle: Coffee – Soda – Chocolate – Tea – Other? How many cups? How many sodas?	
Employment		
	Occupation (past or present):	
Miscellaneous	Have you ever received a blood transfusion? ☐ Yes ☐ No	

Reviewed by MD & discussed with patient _____

REVIEW OF SYSTEMS

Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:

Constitutional

- Fever ☐ Yes ☐ No
- Headache ☐ Yes ☐ No
- Unexplained weight loss ☐ Yes ☐ No
- Other: ____________

HEENT

- Runny nose ☐ Yes ☐ No
- Difficulty hearing ☐ Yes ☐ No
- Other: ____________

Neurologic/Psychiatric

- Numbness ☐ Yes ☐ No
- Tingling ☐ Yes ☐ No
- Weakness ☐ Yes ☐ No
- Dizziness ☐ Yes ☐ No
- Memory loss ☐ Yes ☐ No
- Seizures ☐ Yes ☐ No
- Anxiety ☐ Yes ☐ No
- Spinal cord injury ☐ Yes ☐ No
- Headache ☐ Yes ☐ No
- Difficulty Sleeping ☐ Yes ☐ No
- Other: ____________

Metabolic/Endocrine

- Excessive thirst ☐ Yes ☐ No
- Too hot ☐ Yes ☐ No
- Too cold ☐ Yes ☐ No
- Other: ____________

Immunologic

- Hay fever ☐ Yes ☐ No
- Food allergies ☐ Yes ☐ No
- Other: ____________

Respiratory

- Shortness of breath ☐ Yes ☐ No
- Wheezing ☐ Yes ☐ No
- Cough ☐ Yes ☐ No
- Other: ____________

Musculoskeletal

- Joint pain ☐ Yes ☐ No
- Back pain ☐ Yes ☐ No
- Artificial joints ☐ Yes ☐ No
- Other: ____________

Hematologic

- Easy bruising or bleeding ☐ Yes ☐ No
- Blood clots in arms or legs ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Other: ____________

Cardiovascular

- Chest pain ☐ Yes ☐ No
- Irregular pulse ☐ Yes ☐ No
- Heart attack ☐ Yes ☐ No
- Heart valve problem ☐ Yes ☐ No
- Other: ____________

Genitourinary

- Back Pain ☐ Yes ☐ No
- Cloudy Urine ☐ Yes ☐ No
- Frequent night time urination ☐ Yes ☐ No
- Other: ____________

Gastrointestinal

- Abdominal pain ☐ Yes ☐ No
- Nausea/vomiting ☐ Yes ☐ No
- Indigestion/Heartburn ☐ Yes ☐ No
- Diarrhea ☐ Yes ☐ No
- Constipation ☐ Yes ☐ No
- Other: ____________

Dermatologic

- Rash ☐ Yes ☐ No
- Boils/infections ☐ Yes ☐ No
- Abnormal pigmentation ☐ Yes ☐ No
- Other: ____________

Vascular

- Cool Extremity ☐ Yes ☐ No
- Pain in limb ☐ Yes ☐ No
- Varicose Veins ☐ Yes ☐ No
- Other: ____________

Reviewed by MD & discussed with patient _____

Preferred Pharmacy	
Pharmacy 1 ***Local***	
Name	
Address **City**	
Pharmacy 2 ***Mail Order***	
Name	
Customer #	

Expand here if any other information is needed

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