Patient History Form

Virginia Urology

Please complete the following form and answer all questions so that we may have an updated record of your medical history. Thank you.

Chart #:_____

Today's Date:

Name:	**Phone Number:**	**Date of Birth:**
Your appointment is with:	**Referring Physician:**	

Allergy to:	**Reaction**
Latex Yes ☐ No ☐	
Shellfish Yes ☐ No ☐	
X-Ray Dye Yes ☐ No ☐	
Iodine Yes ☐ No ☐	
Drug Allergies: ☐ **NONE**	**Reaction**

Current Medications, Vitamins & Minerals ☐ **NONE**	**Dose**	**Frequency**

Past Medical Problems:	**YES**	**NO**
Heart Disease	☐	☐
Pacemaker	☐	☐
Defibrillator	☐	☐
Lung Disease	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	☐
Bowel Problems	☐	☐
Stroke/Seizures	☐	☐
Kidney Problems	☐	☐
Bleeding Problems	☐	☐
HIV	☐	☐
Hepatitis	☐	☐
Cancer	☐	☐
Other		

Past Surgeries: ☐ **No Surgeries**

- ☐ Kidney Surgery
- ☐ Lithotripsy
- ☐ Kidney Stone Surgery
- ☐ Bladder Surgery
- ☐ Bladder Tumor Removal
- ☐ Prostate Biopsy
- ☐ Prostatectomy
- ☐ Prostate Surgery
- ☐ Joint Replacement Surgery
- ☐ Open Heart Surgery
- ☐ Heart Valve Surgery
- ☐ Heart Stent Procedure
- ☐ Colon Surgery
- ☐ Hysterectomy
- ☐ Gallbladder Surgery
- ☐ Hernia Repair
- ☐ Other Abdominal Surgery
- ☐ Cataract Surgery

Other

Recent Symptoms

- ☐ Yes ☐ No Increased Urination
- ☐ Yes ☐ No Painful Urination
- ☐ Yes ☐ No Nighttime Urination
- ☐ Yes ☐ No Bloody Urination
- ☐ Yes ☐ No Involuntary Urine Loss
- ☐ Yes ☐ No Back Pain
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Fever
- ☐ Yes ☐ No Unexplained Weight Loss
- ☐ Yes ☐ No Excessive Thirst
- ☐ Yes ☐ No Easy Bleeding
- ☐ Yes ☐ No Blurred Vision
- ☐ Yes ☐ No Hearing Problems
- ☐ Yes ☐ No Numbness
- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No Dry Skin

Pharmacies you currently use:

Name: Phone:

Name: Phone:

Social History Occupation:

☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed

Have you ever smoked? ☐ YES ☐ NO **Currently smoke?** ☐ YES ☐ NO

Do you use smokeless tobacco? ☐ YES ☐ NO

Do you drink alcohol? ☐ No ☐ Occasionally ☐ Frequently

Family History: (not patient) ☐ **Unknown**

Prostate Cancer: Yes ☐ No ☐

Kidney Cancer: Yes ☐ No ☐

Kidney Disease: Yes ☐ No ☐

Kidney Stones: Yes ☐ No ☐