TEXAS UROLOGY SPECIALISTS

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(Please Fill Out Completely)

Date: _____

Home Phone #: _____

Cell Phone #: _____

Work Phone #: _____

Email: _____

Patient Name: _____

Birthdate: _____ Age: _____ Marital Status: M S D W Gender: Male Female

Last Name: _____ First: _____Middle: _____

Address: _____

City: _____ State _____ ZIP_____

Patient Employer: _____ Occupation: _____

Spouse Name: _____ Ok to release Medical Information to spouse? Yes No

The following person(s) are authorized to discuss my medical record and/or personal health information with my Texas Urology Specialists care team on my behalf:

_____ _____

_____ _____

Primary Insurance: _____ ID #: _____

Policy Holder: _____ DOB of holder: _____

Secondary Insurance: _____ ID #: _____

Policy Holder: _____ DOB of holder: _____

Emergency Contact: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

UROLOGY

PATIENT HISTORY FORM

Name _____
Last First Middle

Did another Physician refer you to this office? Yes☐ No ☐

Referring Physician: _____

Primary Care Physician: _____

What other physicians do you see regularly? _____

What is the reason for today's visit? _____

_____

_____

PAST MEDICAL HISTORY

Do you have or have you had any of the following problems?

Ears-Eyes-Nose-Throat
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other _____

Respiratory (Lungs)
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Bronchitis/Emphysema
- ☐ Other _____

Cardiovascular (Heart)
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Blood clots in legs/lungs
- ☐ Heart Failure
- ☐ Other _____

Renal-Genito-Urinary
- ☐ Kidney Failure
- ☐ Kidney Stones

Musculoskeletal
- ☐ Arthritis
- ☐ Back Problem
- ☐ Other _____

Gastrointestinal
- ☐ Ulcer Disease
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Other _____

Hepatic (Liver)
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Other _____

Dermatologic (Skin)
- ☐ Psoriasis
- ☐ Other _____

Central Nervous System (Brain)
- ☐ Epilepsy/Seizure
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Spinal Injury
- ☐ Other _____

Endocrine-Metabolic
- ☐ Diabetes
- ☐ Gout
- ☐ Thyroid Disease
- ☐ Treatment for low testosterone/Other

Psychiatric
- ☐ Depression
- ☐ Mental Illness
- ☐ Other _____

Other Disease
- ☐ IV Drug Use (ever)
- ☐ AIDS
- ☐ HIV Positive
- ☐ Alcoholism
- ☐ Cancer _____
- ☐ Other _____

Blood-Lymph
- ☐ Bleeding Disorder
- ☐ Sickle Cell Disease
- ☐ Other _____

PAST SURGICAL HISTORY

Have you had any procedures or surgeries in your lifetime? ☐ Yes ☐ No

If yes, please list procedures and surgeries along with the approximate date:

*_____ *_____

*_____ *_____

*_____ *_____

UROLOGY

PATIENT HISTORY FORM

OB/GYN HISTORY: Last Menstrual Period _____

# of Pregnancies _____ # of Vaginal Deliveries _____ # of C-Sections _____

ALLERGY:

Are you allergic to medications? ☐ Yes ☐ No

If yes, please list and describe your reaction to the medications (hives, rash, etc.)

_____ _____

_____ _____

MEDICATIONS:

Do you regularly take prescription or non-prescription medication? ☐ Yes ☐ No

If yes, please list medication:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

Are you currently employed? ☐ Yes ☐ No Occupation_____

What is your marital status? ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Have you ever smoked? ☐ Yes ☐ No

Do you still smoke? ☐ Yes ☐ No

If yes, how many packs per day? _____ How many years have you been smoking?_____

If no, when did you quit? _____ Prior to quitting, how many packs per day?____

Do you drink alcohol? ☐ Yes ☐ No Number of drinks per week? _____

What are your hobbies?_____

FAMILY HISTORY:

Has any relative ever had any of the following? If so, please check and state relation (father, etc.)

	Relation		**Relation**
☐ Bladder Cancer	_____	☐ Heart Disease	_____
☐ Kidney Cancer	_____	☐ High Blood Pressure	_____
☐ Prostate Cancer	_____	☐ Diabetes	_____
☐ Other Cancer	_____	☐ Asthma	_____
☐ Kidney Stone	_____	☐ Tuberculosis	_____
☐ Other _____	_____	☐ Other _____	_____

Pharmacy Name / Location: _____ Phone: _____

Email: _____ ☐ Decline Portal

UROLOGY

PATIENT HISTORY FORM

REVIEW OF SYSTEMS

Please check yes or no to all of the following:

Yes	No	General
☐	☐	Weight Loss
☐	☐	Weight Gain
☐	☐	Fatigue
☐	☐	Fever

Yes	No	Musculoskeletal
☐	☐	Back Pain

Yes	No	Cardiovascular
☐	☐	Chest Pain
☐	☐	Palpitations
☐	☐	Edema/Swelling

Yes	No	Gastrointestinal
☐	☐	Constipation
☐	☐	Nausea/Vomiting
☐	☐	Diarrhea

Yes	No	Bleeding
☐	☐	Easy Bruising

Yes	No	Psychologic
☐	☐	Depression
☐	☐	Anxiety

Yes	No	Respiratory
☐	☐	Cough
☐	☐	Shortness of Breath

Yes	No	Genito-Urinary
☐	☐	Blood in Urine
☐	☐	Burning/Pain with urination
☐	☐	Urinary Frequency
☐	☐	Urinary Urgency
☐	☐	Urinating at night _____ # of times
☐	☐	Bladder or Kidney Infection
☐	☐	Urine Leakage w/cough, sneeze, etc.
☐	☐	Incomplete emptying or bladder fullness
☐	☐	Kidney Stones

Yes	No	Men
☐	☐	Erectile Dysfunction
☐	☐	Prostate Problems