Patient name: _____ DOB_____ Date_____

Medical History Form

Reason for Visit Today: _____

Medical Allergies (include dye, etc): _____

CURRENT MEDICATIONS (If additional → Complete on back)

Name	Dose	How often per day	Reason for taking	Name	Dose	How often per day	Reason for taking

PAST MEDICAL HISTORY (Urologic) - Please circle as appropriate

Erectile Dysfunction Elevated PSA Enlarged prostate (BPH) Hypogonadism – "Low T"

Kidney stones Urinary retention Blood in urine (hematuria) Urinary Tract Infections

Prostate Cancer Bladder Cancer Kidney Cancer Testicular cancer

Renal Failure Incontinence (leakage of urine) Pelvic prolapse(cystocele, rectocele)

Other: _____

PAST MEDICAL HISTORY (Non-urologic) – Please circle as appropriate

HEENT: Blindness Cataracts Deafness Glaucoma

Cardiovascular: Heart attack (MI) Hypertension Atrial Fibrillation
Congestive Heart Failure Angina

Respiratory: Asthma COPD Emphysema Pulmonary Embolism(PE)

Gastrointestinal: Crohn's Disease Diverticulitis Hepatitis GERD (reflux)

Endocrine: Diabetes Gout Hypothyroidism Hyperthyroidism

Neurological: Alzheimer's Dz Stroke Parkinson's Dz Multiple sclerosis

Cancer: Breast Colon Lung Lymphoma Ovarian
Other cancer diagnosis: _____

Infectious/Hematologic: Anemia HIV/AIDS Tuberculosis Deep venous thrombosis (DVT)

Other medical conditions

PAST SURGICAL HISTORY (Urologic and Gynecologic) - Please circle as appropriate

Robotic Prostatectomy Open Radical Prostatectomy

Nephrectomy – Open or Laparoscopic Partial Nephrectomy – Open or Laparoscopic

TURP (surgery for enlarged prostate) TURBT (removal of bladder tumor)

ESWL (sound wave treatment of kidney stones) Ureteroscopy – laser or basket removal of stones

Orchiectomy (removal of testicle) Pyeloplasty (for UPJ obstruction)

Prostate Needle Biopsy Endoscopic treatment of urethral stricture

Pelvic Prolapse repair (cystocele, enterocele, rectocele repair – with or without mesh)

Bladder sling for incontinence Bladder suspension for incontinence Hysterectomy

Dates of Surgery/Procedure circled above: 1) _____
(or other surgeries) 2) _____

UrologyAustin

Patient name: _____ DOB_____ Date_____

PAST SURGICAL HISTORY (Non-Urologic):

Type of surgery	Date (approximate)	Hospital or City

FAMILY HISTORY: (Please check where appropriate and specify approximate age of diagnosis)

	Father	Mother	Brother/Sister	Aunts/Uncles	Grandparent	Children	First Cousins	Runs in Family (Specify)
Prostate Cancer								
Breast Cancer (Age 50 or <)								
Colon Cancer								
Ovarian Cancer								
Pancreatic Cancer								
Kidney stones								
Heart Disease								
High Blood pressure								
Diabetes								
Other: _____								

*If Prostate Ca, Breast Ca, Ovarian Ca, or any combination of at least two of these, patient may be eligible for hereditary cancer testing - MyRisk.

SOCIAL HISTORY: (PLEASE CIRCLE THE APPROPRIATE RESPONSE)

Marital Status: Married Single Divorced Widowed Separated Unknown

Smoking status: Current every day smoker Current some day smoker Former smoker Never smoker

Do you drink alcohol: Yes Not anymore Never Drank

How many caffeinated drinks do you drink per day: _____

Have you had a blood transfusion: Yes or No

Language: English Spanish French German Portugese Russian Chinese Other _____

Race: White Black or African American American Indian/Alaska Native Hispanic/Latino Asian Other _____

REVIEW OF SYSTEMS: (PLEASE CIRCLE ANY MEDICAL PROBLEMS LISTED BELOW YOU HAVE)

Constitutional:	NONE	Fever	Weight Loss	Chills
Eyes:	NONE	Blurry vision	Double Vision	Cataracts
Ears, Nose, Throat	NONE	Hearing Loss	Nasal Stuffiness	Sore throat
Cardiovascular:	NONE	Chest pain	Swollen ankles	Irregular heart beat
Respiratory:	NONE	Shortness of breath	Wheezing	Chronic cough
Gastrointestinal	NONE	Abdominal Pain	Nausea/Vomitting	Constipation
Genitourinary	NONE	Incontinence	Painful urination	Blood in urine
Musculoskeletal:	NONE	Arthritis	Chronic back pain	Sore muscles
Integumentary/Skin	NONE	Rash	Persistent itching	Skin cancer history
Neurological	NONE	Numbness	Tingling	Dizziness
Hematological	NONE	Abnormal bleeding	Transfusion history	Swollen glands

Other complaints: _____