

Scottsdale Center for Urology

PATIENT HISTORY FORM

Date: _____

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization.

Last Name _____ First Name _____ MI ____ Nickname _____

DOB: _____ Gender: M F (please circle)

The Medical Board requests that this form be completed every two years.

CHIEF COMPLAINT What is the main reason for your visit today? (Describe your problem in detail)

History of Present Illness

Location of the problem

Abdomen Back Leg Groin

Other: _____

On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other _____

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other _____

How long does the problem last?

30 minutes 1 hour It is always there

Other: _____

Is anything else occurring at the same time?

Yes No If yes, Please explain.

Nausea Rash Headaches Fever Chills

Other: _____

Is the problem constant or variable?

Dull then Sharp Very Sharp then leaves Always there

Other: _____

Does the problem interfere with your normal function?

Yes No If yes, please explain

Medical History

List all illnesses, Example: (diabetes, tuberculosis, breast cancer, heart disease, etc.)

Condition	Year	Condition	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PREVIOUS SURGERIES

Surgery	Year	Surgery	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES _____

LIST ALL DOCTORS AND SPECIALISTS YOU ARE CURRENTLY SEEING

Doctors Name	Specialty
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History of:	Yes	No	Family Member	Yes	No	Family Member
1. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Gastrointestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Other: _____						

Do you currently smoke? If yes, how much did/do you smoke? _____ When did you quit? _____

Do you drink alcohol? If yes, how many drinks per week on average? _____

**Do you have any of the following?
(Please mark an (X) in the spaces provided):**

Constitutional Symptoms	X	Genitourinary	X	Gastrointestinal	X
Weight Change		Change in Stream		Abdominal pain	
Chills		Nocturia (getting up at night)		Nausea/vomiting	
Fever		Urinary frequency > 8times/day		Indigestion/heartburn	
Itching		Burning with urination		Constipation	
Night Sweats		Blood in urine		Diarrhea	
Other:		Trouble starting urine flow		Other:	
		Dribbling at end of urine flow			
		Urinary leakage			
		Other:			
Musculoskeletal	X	EYES	X	Neurological	X
Muscle weakness		Glaucoma		Tremors	
Joint pain (swelling)		Cataracts		Dizzy spells	
Sciatica		Wear glasses		Numbness/tingling	
Muscle pains		Blurred vision/Pain in your eyes		Stroke	
Muscle cramps stiffness		Other:		Seizures	
Other:				Insomnia	
				Other:	

ENT	X	Cardiovascular	X	Respiratory	X
Pain in ears		Chest pain		Wheezing	
Discharge from ears		Tightness/heaviness in chest		Frequent cough	
Motion sickness		Irregular heartbeat		Shortness of breath	
Difficulty hearing		Swelling in ankles		Are you on oxygen?	
Trouble with teeth		High blood pressure		Other:	
Trouble with gums		Shortness of breath			
Nose bleeds		Heart enlarged			
Other:		Low blood pressure			
		Feel palpitations			
		Feel skipped beats			
		Hear pound fast			
		Do you have a murmur?			
Endocrine	X	Hematological/Lymphatic	X	Psychological	X
Excessive thirst		Swollen glands		Do you feel depression?	
Too hot/cold		Blood clotting problems		Do you feel anxious?	
Other:		Bruising		Seeing a psychiatrist	
		Other:		Any psychiatric diagnosis?	
				Other:	
Sexual History	X		X	(MEN ONLY)	X
Change in sex drive?				Pain or swelling of testicles	
Sexual performance Satisfactory?				Discharge from penis	
Other:				Blood in Semen	
				Other:	

MALE ONLY (OVER 40)							
AUA Symptom Score: Circle one number on each line							
Questions to be answered	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Over the past month, how often have you had to urinate less than 2 hours after you finished urinating?	0	1	2	3	4	5	
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5	
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. On a nightly basis, how many times do you typically get up to urinate?	0	1	2	3	4	5	
Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Sum the seven circled numbers (AUA Symptom Score); _____ Scoring: **Mild:** 0-7 **Moderate:** 8-19 **Severe:** 20-35

Patient Signature: _____ Physicians Signature: _____