UROLOGY Care Center

Patient History Form

Michael Mooreville, MD

Note: Confidential

Date: _____

Name: _____

Address: _____

_____

Age: _____ Date of Birth: _____

We would like to send a letter to update your primary physician. YES NO

Primary Physician: _____

Tel. No.: _____

Other Physician: _____

Tel. No.: _____

Note: No letters will be sent without tel. #

Chief Complaint:

What is the main reason for your office visit today (please describe in detail)?

Past Medical and Social History:

1. Do you have any of the following conditions? ***Yes No***

Circle any of the following that apply:
1. High blood pressure
2. High cholesterol
3. Heart Disease
4. Diabetes

_____

2. List all <u>serious</u> illnesses in your immediate family.

_____

_____

3. List any personal treatments and surgical interventions and when they occurred.

Surgery _____ Date _____

Surgery_____ Date _____

Surgery _____ Date _____

Radiation Therapy _____ Date _____

Chemotherapy _____ Date _____

4. Drug Allergies: Yes No
Please list: _____

5. Medications: Yes No
Please list all drugs, medications, eye drops, etc. _____

_____

_____

6. Alcohol Intake: Yes No
If yes: Type _____ Amount _____

7. Tobacco Use: Yes No
If yes: Packs per day _____ How many years? _____ If stopped, when?_____

8. Psychological History:
Have you ever consulted a psychiatrist, psychologist? Yes No
If yes, please describe the reason: _____

_____

Physician's Notes:

Review of Symptoms

Do you now or have you had any problems related to the following symptoms?
Circle Yes or No. **Please explain any "Yes" answers.**

Constitutional Symptoms			**Endocrine**		
Fever	Yes	No	Excessive thirst	Yes	No
Chills	Yes	No	Too hot/cold	Yes	No
Headaches	Yes	No	Tired/sluggish	Yes	No
Weight loss	Yes	No	Other		
Other					

Genitourinary			**Gastrointestinal**		
Urinary retention	Yes	No	Abdominal pain	Yes	No
Painful urination	Yes	No	Nausea/vomiting	Yes	No
Urinary frequency	Yes	No	Indigestion	Yes	No
Other			Other		

Cardiovascular			**Respiratory**		
Chest pain	Yes	No	Wheezing	Yes	No
Varicose veins	Yes	No	Frequent coughs	Yes	No
High blood pressure	Yes	No	Shortness of breath	Yes	No
Other			Other		

Musculoskeletal			**Neurologic**		
Joint pain	Yes	No	Tremors	Yes	No
Neck pain	Yes	No	Dizzy spells	Yes	No
Back pain	Yes	No	Numbness	Yes	No
Other			Other		

Hematological/Lymphatic			**Allergic/Immunologic**		
Swollen glands	Yes	No	Hay fever	Yes	No
Blood clot problems	Yes	No	Drug allergies	Yes	No
Other			Other		

Additional Information