

Urological Specialists of Virginia
Patient History/History Updated Form

Chart# _____
Name: _____
DOB: _____
Current Occupation: _____

Today's Date: _____
Family Dr: _____
Referring Dr: _____
Marital Status: _____

Annual Medical History Review By The Patient:

Month ___ Day ___ Year ___
Month ___ Day ___ Year ___
Month ___ Day ___ Year ___
Month ___ Day ___ Year ___

Please circle:

1. Have you been told you have?

- | | | | | | |
|---------------------------|-----|----|-----------------------|-----|----|
| • Heart Disease | Yes | No | • Diabetes | Yes | No |
| • Pacemaker/Defibrillator | Yes | No | • Bowel Problems | Yes | No |
| • Lung Disease | Yes | No | • HIV | Yes | No |
| • High Blood Pressure | Yes | No | • Hepatitis | Yes | No |
| • Stroke/Seizure | Yes | No | • Cancer | Yes | No |
| • Bleeding Problems | Yes | No | • GI/Digestive Issues | Yes | No |
| • Glaucoma | Yes | No | • Cataracts | Yes | No |
| • Arthritis | Yes | No | • Skin Problems | Yes | No |

Urological History:

- | | | | | | |
|---------------------|-----|----|---------------------|-----|----|
| • Stones | Yes | No | BPH/Large Prostate | Yes | No |
| • Kidney Tumor | Yes | No | Prostate Cancer | Yes | No |
| • Dialysis | Yes | No | Erection Problem | Yes | No |
| • Kidney Infection | Yes | No | Sexually Trans Dis. | Yes | No |
| • Bladder Infection | Yes | No | Rash/Warts | Yes | No |
| • Bladder Tumor | Yes | No | | | |
| • Incontinence | Yes | No | | | |

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2. **Past Surgeries:** Yes No
 If yes, what kind Year

3. **Family History:**
· Prostate Cancer Yes No
· Kidney Cancer Yes No
· Kidney Stones Yes No
· Kidney Disease Yes No
· Diabetes Yes No
· Heart Disease Yes No

4. **Smoking History:** Never Smoked _____, Smoke _____ PPD, Quit _____ years ago.

5. **Alcohol:** Don't Drink _____, Rarely _____, _____ Drinks/week, _____ Drinks/day.

6. **Review of Systems:**

· Increased Urination	Yes	No	· Easy Bleeding	Yes	No
· Unexplained Weight Loss	Yes	No	· Hearing Problems	Yes	No
· Fever	Yes	No	· Wheezing	Yes	No
· Excessive Thirst	Yes	No	· Numbness	Yes	No
· Painful Urination	Yes	No	· Blurred Vision	Yes	No
· Back Pain	Yes	No	· Nausea	Yes	No
· Nighttime urination	Yes	No	· Dry Skin	Yes	No
· Bloody Urination	Yes	No	· Incontinence	Yes	No
· Chest Pain	Yes	No	· Blood on Stools	Yes	No
· Dizziness	Yes	No	· Pain/Swelling in Joints	Yes	No

Notes: _____

Gynecological History: Number of Pregnancies _____, Vaginal Delivers _____

C-sections _____, Hysterectomy Yes or No Type: vaginal/abdominal.

Name _____ Chart# _____

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7. Current Medications: or No Medications

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

8. Drug Allergies: or No Allergies
If yes, List Drugs and reaction

Are you Allergic to:

Yes	No	Latex
Yes	No	Shellfish
Yes	No	X-Ray Dye
Yes	No	Iodine

Notes:

Annual Medical History Review By The Provider: Month ___ Day ___ Year ___
Month ___ Day ___ Year ___
Month ___ Day ___ Year ___
Month ___ Day ___ Year ___

Name _____ Chart# _____