PATIENT HISTORY FORM

Last Name: _____ First: _____ Middle: _____

Today's Date: ___/___/___ Date of Birth: ___/___/___

You live with (circle) spouse family self at a nursing home

MEDICATIONS

Name	Milligrams (amount)	Times a Day

MD USE ONLY

List any Medication Allergies:

List any Allergies:

Dye Y N Iodine Y N

Seafood Y N Latex Y N

Other: _____

List Any Past Surgeries:

Type	Date (Year only)

Your Other Medical Illnesses:

			WHEN
Lung Disease	Y	N	
Diabetes	Y	N	
Heart Attack	Y	N	
Stroke	Y	N	
Tuberculosis	Y	N	
HIgh Blood Pressure	Y	N	
Heart Murmur	Y	N	
Arthritis	Y	N	
Sleep Apnea	Y	N	

Other: _____

Family History Of:

Prostate Cancer Y N

Heart Disease Y N

Diabetes Y N

Cancer Y N

Other: _____

Social History

Do you smoke? Y N How much? _____

Do you drink alcohol? Y N How much?

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided

Constitutional Symptoms
- Fever Y N
- Chills Y N
- Headache Y N
- Other: _____

Eyes
- Blurred Vision Y N
- Double Vision Y N
- Pain Y N
- Other: _____

Allergic / Immunologic
- Hay Fever Y N
- Drug Allergies Y N
- Other: _____

Neurological
- Tremors Y N
- Dizzy Spells Y N
- Numbness/tingling Y N
- Other: _____

Endocrine
- Excessive Thirst Y N
- Too Hot/Cold Y N
- Tired/Sluggish Y N
- Other: _____

Gastrointestinal
- Abdominal Pain Y N
- Nausea/Vomiting Y N
- Indigestion/Heartburn Y N
- Other: _____

Cardiovascular
- Chest Pain Y N
- Varicose Veins Y N
- High Blood Pressure Y N
- Other: _____

Integumentary
- Skin Rash Y N
- Boils Y N
- Persistent Itch Y N
- Other: _____

Musculoskeletal
- Joint Pain Y N
- Neck Pain Y N
- Back Pain Y N
- Other: _____

Ear/Nose/Throat/Mouth
- Ear Infection Y N
- Sore Throat Y N
- Sinus Problems Y N
- Other: _____

Respiratory
- Wheezing Y N
- Frequent Cough Y N
- Shortness of Breath Y N
- Other: _____

Hematologic / Lymphatic
- Swollen glands Y N
- Blood Clotting problem Y N
- Other: _____

Psychologic
- Are you generally satisfied with your life? Y N
- Do you feel severely depressed? Y N
- Have you considered suicide? Y N
- Other: _____

Genitourinary
- Painful urination Y N
- Bloody urination Y N
- Urine retention Y N
- Air in urine stream Y N
- Urinary incontinence Y N

American Urological Association (AUA) Symptom Index[1]

Questions to be answered	AUA Symptom Score (Circle one number on each line)					
	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 again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month, how ofter 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. Over the past month, how may times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0 (none)	1 (1 time)	2 (2 times)	3 (3 times)	4 (4 times)	5 (5 times)

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