Lubbock Urology Clinic, L.L.P.

PATIENT HISTORY

Name:_____ **SSN#**_____ **DOB:**_____ **Date:**_____

Referring Doctor:_____ Family Doctor:_____

Cardiologist: _____

Why are you seeing the doctor today?_____

How long have you had this problem? _____

What improves or worsens the problem/pain?_____

Are there any symptoms that go along with the problem/pain? _____

Is the problem/pain continuous or does it come and go? _____

Describe the pain if you have pain (sharp/dull, etc.) _____

Have you tried any medicine/treatment for this problem/pain? _____

PAST MEDICAL HISTORY

Please mark (X) if you have or have had any of the following diseases or conditions:

CARDIOVASCULAR:

____ Anemia
____ Angina
____ Anorexia
____ Aortic Aneurysm
____ Aortic Insufficiency
____Aortic Stenosis
____Arrhythmia
____Atrial Fibrillation
____Bleeding Disorder
____Cerebrovascular Disease
____Congenital Heart Disease
____Congestive Heart Failure
____Deep Vein Thrombosis
____Enlarged Heart
____Heart Attack
____Heart Disease
____Heart Murmur
____Heart Valve Problem
____Hemophilia
____Hypertension
____Luekemia
____Mitral Insufficiency
____Mitral Stenosis
____Rheumatic Fever
____Sickle Cell Anemia
____Stroke
____Other_____

ENDOCRINE/METABOLIC:

____Diabetes Mellitus-(non-insulin dependent)
____Diabetes Mellitus-(insulin dependent)
____Diabetes Mellitus-(uncontrolled)
____Goiter
____Gout
____Hyperthyroidism
____Impaired Glucose Tolerance
____Other:_____

GENERAL:

____Allergies
____Hepatitis ___
____High Cholesterol
____Infectious Disease
____Lipid Disorder
____Malaise
____Obesity
____Phlebitis
____Sleep Apnea
____Other:_____

GASTROINTESTINAL:

____Cholecystitis
____Cholelethiasis
____Chronic Liver Disease
____Colitis
____Constipation
____Colon Condition
____Crohn's Disease
____Diarrhea
____Diverticulitis
____Diverticulosis
____GERD
____Hemorrhoids
____Hiatal Hernia
____Inflammatory Bowel Disease
____Liver Disease
____Pancreatitis
____Peptic Ulcer
____Rectal Fissure
____Stomach Ulcer
____Other:_____

GENITOURINARY:

____Acute Prostatitis
____AIDS
____Benign Prostatic Hypertrophy
____Bladder Infection
____Chronic Prostatitis
____Chronic Renal Insufficiency
____Chronic Renal Failure
____Elevated PSA
____Epididymitis
____HIV
____HPV
____Interstitial Cystitis
____Kidney Disease
____Kidney Infection
____Kidney Stones
____Penile Discharge
____Prostate Cancer
____Undescended Testicle
____Urinary Tract Infection
____Venereal Disease
____Bladder Cancer
____Erectile Dysfunction
____Infertility
____Pre-mature ejaculation
____Testicular Cancer
____Other:_____

HEENT:

____Blindness
____Cataracts
____Deafness
____Ear Infection
____Glaucoma
____Hay Fever
____Mumps
____Vertigo
____Other:_____

MUSCULOSKELETAL:

____Arthritis
____Back Pain
____Carpal Tunnel Syndrome
____Fibromyalgia
____Other:_____

Neurological/Psychological:

____ADD
____ADHD
____Alcoholism
____Alzheimer's Disease
_____Anxiety Disorder
____Bi-Polar
____Chronic Fatigue Syndrome
____Depression
____Eating Disorder
____Epilepsy
____Herniated Disc
____Mental Illness
____Migraine
____Nervous Breakdown
____Parkinson's Disease
____Polio
____Stroke
____Suicide Attempt
____Other:_____

RESPIRATORY:

____Asthma
____Bronchitis
____Chronic Lung Disease
____COPD
____Emphysema
____Pulmonary Embolism
____Tuberculosis
____Other:_____

TUMORS:

____Brain Tumors
____Breast Cancer
____Cervical Cancer
____Colon Cancer
____Gastric Cancer
____Laryngeal Cancer
____Lung Cancer
____Lymphoma
____Melanoma
____Pancreatic Cancer
____Rectal Cancer
____Other:_____

Print Name_____

SURGICAL HISTORY

Please list any surgeries you have had and date of surgery:

_____

_____

_____

_____

FAMILY HISTORY

Please mark (X) if a parent, sibling, aunt, uncle and/or grandparent has/had any of the following.:

Mark (X) if applies	Condition:	Relationship to you:
	Arthritis	
	Bedwetting	
	Bladder Cancer	
	Cancer:	
	Crohn's Disease	
	Depression	
	Diabetes	
	Gout	
	Heart Attack	
	Hypertension	
	Kidney Disease, *Please specify*:	
	Kidney Stones	
	Leukemia	
	Malignant Melanoma	
	Multiple Sclerosis	
	Laryngeal Cancer	
	Pancreatic Cancer	
	Prostate Cancer	
	Stroke	
	Thyroid Disease	
	Tuberculosis	
	Other:	

SOCIAL HISTORY

Please provide the following information:

Advanced Directives:

☐ Living Will ☐ Durable Power Of Attorney ☐ Do Not Resuscitate (DNR) ☐ Organ Donor

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Common Law Spouse

Occupation – Please CIRCLE the one that applies:

None Laborer Truck Driver Tradesman Clerk Administrative Executive Professional Part-Time Retired Other :_____

Alcohol Consumption:

_____None _____Yes Occasional / Social # of drinks per day _____

Tobacco per day:

_____None _____Yes #_____Packs/day _____Cigarettes/day _____Smokeless Tobacco

If you previously stopped smoking when? _____

Recreational Drugs: _____ None If Yes, please list: _____

Caffeinated beverages: _____None _____Low _____Moderate _____Excessive

Print Name_____

ALLERGIES- Please list ALL types (Drug, Seasonal, Pets, Environmental, foods)

_____

_____

_____

PHARMACY NAME: _____ **PHONE#** _____

PHARMACY ADDRESS: _____**City:**_____**State:**_____**Zip:**_____

CURRENT MEDICATIONS- Please list ALL medications you are currently taking including over the counter

Medicine: Drug name:	**Strength:**	**Directions/How you take it:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Attach medication list if necessary

FEMALE HISTORY:

Number of pregnancies _____ Episiotomy: Y/N

Deliveries: Vaginal _____ Cesarean _____ Miscarriages(s):_____ Abortions(s) _____

REVIEW OF SYSTEMS:

Please mark (x) if you have any of the following:

CONSTITUTIONAL:
____Chills ____Fatigue ____Fever ____Night Sweats ____Victim of Domestic Violence ____Weight Gain ____Weight Loss

EYES:
____Blurred Vision ____Eye drainage ____Eye pain ____Glasses/Contacts _____Photophobia

EARS/NOSE/THROAT:
____Ear pain ____Hearing problems ____Tinnitus ____Epitaxis ____Nasal congestion ____Non healing nasal ulcer
____Rhinorrhea ____Bleeding gums ____Peridontal disease ____Dentures ____Hoarseness ____Sore/Ulcer in mouth
____Sore throat ____Sore tongue ____Thrush ____Tooth pain

CARDIOVASCULAR:
____Chest pain ____Claudication ____Dizziness ___Orthopnea ____Palpitations ____Paroxysmal nocturnal dyspnea
____Pedal edema ____Tachycardia ____Varicose veins

RESPIRATORY:
____Acute cough ____Chronic Cough ____Dyspnea ____Exposure to TB ____Hemoptysis ___Pleuritic pain ___Wheezing

Print Name_____

GASTROINTESTINAL:
_____Abdominal pain ____Acid reflux ____Anorexia ___Bloating ___Dysphagia ____Clay colored stool ___Constipation
_____Diarrhea ____Heartburn ____Hematemesis ____Hematochezia ____Hemorrhoids ___Melena ____Nausea ____Vomiting
_____Odynophagia ____Stool caliber change

GENITOURINARY:
____Dysmenorrhe ___Dysparina ___Dysuria ___Genital lesions ___Hematuria ___High risk sexual behavior ___HX UTI's
____HX Bacterial vaginosis ___Irregular menstrual cycles ___Menorrhagia ___Nocturia ___Polyuria ___Hx Rape
____Post coital vaginal bleeding ___Post menopausal bleeding ___Sexual abuse ___Urinary Incontinence ___Vaginal discharge
____Vaginal itching ___Unprotected intercourse ___Impotence ___Urine stream change

MUSCULOSKELETAL:
___Arthralgias ___Back pain ___Joint stiffness ___Limb pain ___Myalgias

INTEGUMENTARY/BREAST:
___Acne ___Atypical mole ___Dry skin ___Fungal nail infection ___Jaundice ___Pruritis ___rash(es) ___Wart(s) ___Breast mass
___Breast skin changes ___Breast tenderness ___Nipple discharge
Yes or No Self Breast Exams

NEUROLOGICAL:
___Ataxia ___Dizziness ___Fainting ___Headaches ___Memory loss ___Paresthesia ___Seizures ___Tremor ___Vertigo
___Weakness

HEMATOLOGIC/LYMPHATIC:
____Easy bruising ____Excessive bleeding ____HX. Of blood transfusion ____Lymphadenopathy

ENDOCRINE:
____enlarged hands/feet ____Hair loss ____Heat/cold intolerance ____Hirsutism ____Hot flashes
____Increased skin pigmentation ____Infertility ____Polydipsia ____Striae ____Excessive sweating

ALLERGIC/IMMUNOLOGIC:
____Seasonal allergies/"hayfever" ____Perennial allergies ____Frequent URI's ____HIV risk factors ____Urticaria

PSYCHIATRIC:
____Anxiety ____Crying spells ____Depression ____Feeling Stressed ____Loss of interest in pleasure
____Mood swings ____Personality changes ____PMS ____Poor concentration ____Recreational drug use
____Sadness ____Sleep disturbances ____Suicidal thoughts

Patient Signature:_____ Date: _____