ALASKA UROLOGY

# Medical History Sheet

**Patient Name:** _____ **Date of Birth:** _____
**General Physician:** _____ **Referring Physician:** _____
**Reason for Today's Visit:** _____
**Medical History: (please mark all you have <u>ever</u> been treated for or are <u>currently</u> being treated)**

- ❑ No Medical History

*General*

- ❑ Bleeding Disorder
- ❑ Glaucoma
- ❑ HIV/AIDS
- ❑ MRSA
- ❑ Rheumatic Fever
- ❑ Systemic Lupus Erythematosus
- ❑ Transplant Recipient, Organ:_____

*Cardiovascular*

- ❑ Aortic Abnormality:_____
- ❑ Atrial Fibrillation
- ❑ Blood Transfusion, Date:_____
- ❑ Congestive Heart Failure
- ❑ Coronary Artery Disease
- ❑ Clot in Leg or Lung
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Valve Disorder, Type:_____
- ❑ High Blood Pressure

*Endocrine/Metabolic*

- ❑ Diabetes
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Low Testosterone

*Respiratory*

- ❑ Asthma
- ❑ COPD
- ❑ Emphysema
- ❑ Sleep Apnea
  - ❑ Use CPAP

*Gastrointestinal*

- ❑ Acid Reflux/GERD
- ❑ Crohn's Disease
- ❑ Hepatitis
- ❑ Stomach Ulcer
- ❑ Ulcerative Colitis

*Genitourinary*

- ❑ Chronic Kidney Disease
- ❑ Genital Herpes
- ❑ Genital Warts
- ❑ Interstitial Cystitis
- ❑ Kidney Stones
- ❑ Renal Failure
- ❑ STD:_____
- ❑ Urinary Tract Infections

*Men's Health*

- ❑ BPH
- ❑ Hydrocele/Spermatocele
- ❑ Prostatitis

*Women's Health*

- ❑ Endometriosis
- ❑ Uterine Fibroids

*Musculoskeletal*

- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Chronic Back Pain
- ❑ Fibromyalgia
- ❑ Gout

*Neuro/Psych*

- ❑ Alzheimer's Disease
- ❑ Anxiety
- ❑ Parkinson's Disease
- ❑ Multiple Sclerosis
- ❑ Psychiatric Diagnosis:_____
- ❑ Spinal Cord Injury, Level:_____
- ❑ Stroke/TIA

*Cancer*

- ❑ Bladder
- ❑ Colon/Rectal
- ❑ Female, Type:_____
- ❑ Kidney
- ❑ Penile
- ❑ Prostate
- ❑ Testicular
- ❑ Other:_____

Other Medical History:_____

_____

***Please complete back side****

**Immunizations:**

Is the patient up to date on immunizations? Yes No

**Female Health History:**

Date of Last Menstrual Period:_____ Post-Menopausal: Yes No

Pregnancies#_____ Live Births#_____ Abortions (elective or spontaneous)# ____

**Male Health History:**

Date of Last PSA:_____

Date of Last Prostate Exam:_____ Normal_____ Abnormal_____

**Recent Studies or Labs:**

What: _____ Where:_____ Date: _____

What: _____ Where: _____ Date: _____

**Surgical History: (please list <u>ALL</u> surgeries you have ever had) *if additional space needed, please ask.**

Vasectomy Date: _____ Hysterectomy Date: _____

_____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____

**Family History: (please list type of cancer) *if additional space needed, please ask**

| *Condition* | *Relative(s)* | *Age of Diagnosis* | *Living/Passed* |
|---|---|---|---|
| Cancer: | | | |
| Cancer: | | | |
| Diabetes | | | |
| Heart Attack | | | |
| Heart Disease | | | |
| High Blood Pressure | | | |
| Kidney Stones | | | |
| Kidney Failure | | | |
| Other: | | | |

**Social History: (circle or fill in appropriate response)**

*Marital Status:*

____Single ____Divorced # of Children:_____

____Married ____Widowed

*Current Alcohol Consumption:* No Yes _____drink per day

History of Alcohol Abuse: No Yes _____ days/months/years sober

*Current Tobacco Use:* No Yes cigarettes/cigars/chew _____packs per day

History of Tobacco Use: No Yes Age start? _____ Age stop? _____

*Recreational Drug Use:*

____None ____Current, name substance(s)_____

____Former, name substance(s)_____ _____days/mos/yrs sober

*Daily Fluid Intake:*

_____ 8 oz. cups of coffee per day _____ 8 oz glasses of water per day

_____ 8 oz. glasses of tea per day

_____ 8 oz. glasses of milk per day

**Patient Signature:** _____ **Date:** _____

**Nurse/MA Signature:** _____ **Date:** _____