

**East Tennessee Urologic Associates
New Patient Medical History**

Today's Date _____

Patient's Name _____ Date of Birth _____

Referring Physician _____

Reason for today's visit _____

Pharmacy Name and phone number _____

Current Medications

List all medications you are presently taking: Dosage: Frequency

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Have you ever had an allergic reaction to any medications __ yes __ no

If yes, list medications and describe reaction _____

Do you have any other Allergies _____

Social History

Number of children _____ Ages _____

Tobacco use: __ never __ now __ in the past How much each day _____

How many years _____

When did you quit _____

Alcohol use: __ never __ now __ in the past How much each day _____

How many years _____

Recreational Drug use: __ never __ now __ in the past

Caffeine use: __ never __ now __ in the past How much each day ____ coffee

_____ tea _____ soda/cola

Personal Medical History

Previous surgeries (please list surgery and year):

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Previous Hospitalizations (please list and year):

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Have you had any serious injuries, broken bones, etc? yes no please list:

Family History

Mother, Father, Brothers, or Sisters

Please check illnesses that have occurred in family members

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood Pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Bleeding tendencies |
| <input type="checkbox"/> Urinary Tract | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Alcoholism | |

Review of Symptoms (do you now have or have you ever had...)

Significant weight change y n increase/decrease by _____ pounds

- | | | | |
|------------------------------------|---|-------------------------|---|
| Eye disease/injury | <input type="checkbox"/> y <input type="checkbox"/> n | Convulsions | <input type="checkbox"/> y <input type="checkbox"/> n |
| Ear disease/injury | <input type="checkbox"/> y <input type="checkbox"/> n | Pain radiating down arm | <input type="checkbox"/> y <input type="checkbox"/> n |
| Nose/sinus/mouth or throat trouble | <input type="checkbox"/> y <input type="checkbox"/> n | Shortness of breath | <input type="checkbox"/> y <input type="checkbox"/> n |
| Bleeding gums | <input type="checkbox"/> y <input type="checkbox"/> n | Burning on urination | <input type="checkbox"/> y <input type="checkbox"/> n |
| Trouble swallowing | <input type="checkbox"/> y <input type="checkbox"/> n | Loss of bladder control | <input type="checkbox"/> y <input type="checkbox"/> n |
| Chest pain or tightness | <input type="checkbox"/> y <input type="checkbox"/> n | Blood in urine | <input type="checkbox"/> y <input type="checkbox"/> n |
| Coughing up blood | <input type="checkbox"/> y <input type="checkbox"/> n | Frequent urination | <input type="checkbox"/> y <input type="checkbox"/> n |
| Night sweats | <input type="checkbox"/> y <input type="checkbox"/> n | Trouble with erections | <input type="checkbox"/> y <input type="checkbox"/> n |
| Heart palpitations | <input type="checkbox"/> y <input type="checkbox"/> n | Painful intercourse | <input type="checkbox"/> y <input type="checkbox"/> n |
| Swelling of hands/feet | <input type="checkbox"/> y <input type="checkbox"/> n | Breast lumps | <input type="checkbox"/> y <input type="checkbox"/> n |
| Weakness in arms or legs | <input type="checkbox"/> y <input type="checkbox"/> n | Severe headaches | <input type="checkbox"/> y <input type="checkbox"/> n |
| Varicose veins | <input type="checkbox"/> y <input type="checkbox"/> n | Paralysis | <input type="checkbox"/> y <input type="checkbox"/> n |
| Stomach/ulcer disease | <input type="checkbox"/> y <input type="checkbox"/> n | Enlarged glands | <input type="checkbox"/> y <input type="checkbox"/> n |
| Constipation/diarrhea | <input type="checkbox"/> y <input type="checkbox"/> n | Thyroid/Goiter disease | <input type="checkbox"/> y <input type="checkbox"/> n |
| Hemorrhoids/ rectal bleeding | <input type="checkbox"/> y <input type="checkbox"/> n | Pain in joints/ gout | <input type="checkbox"/> y <input type="checkbox"/> n |
| Fainting spells | <input type="checkbox"/> y <input type="checkbox"/> n | Skin irritations | <input type="checkbox"/> y <input type="checkbox"/> n |
| Loss of consciousness | <input type="checkbox"/> y <input type="checkbox"/> n | Depression/anxiety | <input type="checkbox"/> y <input type="checkbox"/> n |
| Dizziness | <input type="checkbox"/> y <input type="checkbox"/> n | Hallucinations | <input type="checkbox"/> y <input type="checkbox"/> n |
| HIV/AIDS | <input type="checkbox"/> y <input type="checkbox"/> n | Hepatitis/ type _____ | <input type="checkbox"/> y <input type="checkbox"/> n |

Past Urologic History

Urinary tract infection yes no
Type: bladder/Cystitis Kidney
Frequency: less than once a year several times a year
Symptoms: involved high fever and pain
Treatment: Previously evaluated by whom and where _____

History of venereal disease _____ date _____ treatment _____

History of prostatitis _____ date _____ treatment _____

History of stones _____ date _____ treatment _____

History of urinary tract cancer :
Kidney Bladder Prostate Testis Penile
Date _____ Treatments _____

Previous urologic procedures with date:

MALE ONLY

Prostate cancer screening (PSA) y n date _____ results _____

Sexual Dysfunction:
Decrease desire for sex Decrease frequency of erections maintaining erections
Premature ejaculation Painful erections Painful intercourse

FEMALES ONLY

Date of last PAP _____, last mammogram _____
Last menstrual period _____ Birth Control Method _____
Number of pregnancies _____ Number of miscarriages _____

Questions for your doctor today:

