

**CORPUS CHRISTI UROLOGY GROUP
CONFIDENTIAL HEALTH HISTORY**

Name _____ Age _____ Birth date _____ Today's Date _____
 Gender M or F Date of last physical examination _____ PCP/Referring Physician _____
 What is your reason for today's visit? _____

| | | | | | | | | |
|--|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|
| Have x-ray's been taken? <input type="checkbox"/> No <input type="checkbox"/> Yes | | If yes, where: _____ | Ordered by: _____ | Date / / | | | | |
| PAST HISTORY Check (✓) symptoms you currently have or have had in the past. | | | | | | | | |
| ENDOCRINE | Current | Past | GI (Abdominal Symptoms) | Current | Past | LUNGS | Current | Past |
| Hypothyroid | <input type="checkbox"/> | <input type="checkbox"/> | Crohn's Disease | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Hyperthyroid | <input type="checkbox"/> | <input type="checkbox"/> | Cirrhosis of Liver | <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes Number of years _____ | | | GE Reflux | <input type="checkbox"/> | <input type="checkbox"/> | COPD (Emphysema) | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | | | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> |
| CANCER | Current | Past | Indicate Type (circle one) B or C | | | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Bladder | <input type="checkbox"/> | <input type="checkbox"/> | Irritable Bowl Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ | | |
| Genitalia | <input type="checkbox"/> | <input type="checkbox"/> | Liver Failure | <input type="checkbox"/> | <input type="checkbox"/> | MUSCULOSKELETAL | Current | Past |
| Kidney | <input type="checkbox"/> | <input type="checkbox"/> | Ulcerative Colitis | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Urethra | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Gout | <input type="checkbox"/> | <input type="checkbox"/> |
| Testicles | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ | | | Lupus | <input type="checkbox"/> | <input type="checkbox"/> |
| Ureter | <input type="checkbox"/> | <input type="checkbox"/> | HEART | Current | Past | Other: _____ | | |
| Prostate | <input type="checkbox"/> | <input type="checkbox"/> | Congestive Heart Failure | <input type="checkbox"/> | <input type="checkbox"/> | NEUROLOGIC | Current | Past |
| Other: _____ | | | Coronary Artery Disease | <input type="checkbox"/> | <input type="checkbox"/> | Migraine Headache | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | | | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis | <input type="checkbox"/> | <input type="checkbox"/> |
| EYES | Current | Past | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Seizure Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Blindness | <input type="checkbox"/> | <input type="checkbox"/> | Heart Valve Replacement | <input type="checkbox"/> | <input type="checkbox"/> | Spinal Injury | <input type="checkbox"/> | <input type="checkbox"/> |
| Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | Side Effected (circle one) Left Right | | |
| Other: _____ | | | Other: _____ | | | Other: _____ | | |
| GU (Urinary Symptoms) | Current | Past | HEMAT/LYMPH | Current | Past | PSYCHIATRIC | Current | Past |
| Endometriosis | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor Kidney Function | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Chemical Dependency | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Failure | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| When do you dialysis (circle one) M T W Th F S Su | | | HIV Positive | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | | | Mumps | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ | | |
| Other: _____ | | | Other: _____ | | | | | |

| SURGERIES | | |
|-----------|----------|--------------|
| Year | Hospital | Surgery Type |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Have you ever had a blood transfusion? No Yes If yes, please give approximate dates. _____

| MEDICATIONS & SUPPLEMENTS | ALLERGIES |
|---------------------------|-----------|
| | |
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| | |
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| | |
| | |

PHARMACY NAME: _____ PHONE: _____

| GYNECOLOGIC HISTORY | | | |
|---------------------|--------------|---|----------------------|
| Year of Birth | Sex of Child | Type of Delivery | Complications if any |
| | | <input type="checkbox"/> C-Section <input type="checkbox"/> Vaginal | |
| | | <input type="checkbox"/> C-Section <input type="checkbox"/> Vaginal | |
| | | <input type="checkbox"/> C-Section <input type="checkbox"/> Vaginal | |
| | | <input type="checkbox"/> C-Section <input type="checkbox"/> Vaginal | |

Date of last period / / Is your menstrual cycle (circle one) Normal Irregular Heavy Light Are you Pregnant No Yes

HEALTH HABITS Check (✓) if yes and describe how much you use.

Do you / did you ever drink alcohol?
 No Yes What type? _____ How much per week? _____ For how many years? _____ When did you stop? _____

Do you / did you ever use tobacco?
 No Yes What type? _____ How much per day? _____ For how many years? _____ When did you stop? _____

Do you / did you ever use any other recreational or prescription drugs?
 No Yes What type? _____ How much per day? _____ When did you start? _____ When did you stop? _____

OCCUPATIONAL CONCERNS

Occupation (If retired, please list previous occupations and current activities)

SOCIAL HISTORY

Marital Status (circle one) Single Married Widowed Divorced Number of children living at home: _____

FAMILY HISTORY Fill in health information about your family.

| Relation | Age | State of health Living and Well | Age at Death | Cause of Death |
|----------|-----|------------------------------------|--------------|----------------|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| | | | | |

Check (✓) if your blood relatives have had any of the following:

| Disease | Relationship to you | Disease | Relationship to you |
|--|---------------------|--|---------------------|
| <input type="checkbox"/> Arthritis, Gout | | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Asthma | | <input type="checkbox"/> Kidney Cancer | |
| <input type="checkbox"/> Breast Cancer | | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Cancer Type: _____ | | <input type="checkbox"/> Kidney Stones | |
| <input type="checkbox"/> Chemical Dependency | | <input type="checkbox"/> Prostate Cancer | |
| <input type="checkbox"/> Diabetes | | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Heart Disease | | | |

REVIEW OF SYSTEMS Check (✓) symptoms you currently have or have had in the past.

| | | |
|--|--|---|
| <p>CONSTITUTIONAL Current Past</p> <p>Chills <input type="checkbox"/> <input type="checkbox"/></p> <p>Fever <input type="checkbox"/> <input type="checkbox"/></p> <p>Weight Gain <input type="checkbox"/> <input type="checkbox"/></p> <p>Weight Loss <input type="checkbox"/> <input type="checkbox"/></p> <p>ENDOCRINE Current Past</p> <p>Excessive Thirst <input type="checkbox"/> <input type="checkbox"/></p> <p>Hair Loss <input type="checkbox"/> <input type="checkbox"/></p> <p>Heat / Cold Intolerance <input type="checkbox"/> <input type="checkbox"/></p> <p>ENT Current Past</p> <p>Dental Problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty Swallowing <input type="checkbox"/> <input type="checkbox"/></p> <p>Loss of Hearing <input type="checkbox"/> <input type="checkbox"/></p> <p>Ringin in Ears <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus Problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Sore Throat <input type="checkbox"/> <input type="checkbox"/></p> <p>EYES Current Past</p> <p>Blurred Vision <input type="checkbox"/> <input type="checkbox"/></p> <p>Visual Changes <input type="checkbox"/> <input type="checkbox"/></p> <p>GI (Abdominal Symptoms) Current Past</p> <p>Abdominal Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Bloody Stool <input type="checkbox"/> <input type="checkbox"/></p> <p>Constipation <input type="checkbox"/> <input type="checkbox"/></p> <p>Diarrhea <input type="checkbox"/> <input type="checkbox"/></p> <p>Indigestion <input type="checkbox"/> <input type="checkbox"/></p> <p>Nausea <input type="checkbox"/> <input type="checkbox"/></p> <p>Vomiting <input type="checkbox"/> <input type="checkbox"/></p> <p>HEART Current Past</p> <p>Chest Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest Pressure <input type="checkbox"/> <input type="checkbox"/></p> <p>Rapid/Irregular Heartbeat <input type="checkbox"/> <input type="checkbox"/></p> <p>Swelling of Ankles <input type="checkbox"/> <input type="checkbox"/></p> | <p>GU (Problems with Urination) Current Past</p> <p><input type="checkbox"/> Blood in Urine <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Flank Pain <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Hesitancy <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Incomplete Voiding <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Infertility <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Kidney Stones <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Lack of Control <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Painful Urination <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Slow Stream <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Urgency <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Urinating at Night <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Urinating Often <input type="checkbox"/> <input type="checkbox"/></p> <p>WOMEN ONLY Current Past</p> <p><input type="checkbox"/> Abnormal Pap <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Vaginal Infections <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Breast Lump <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Hot Flashes <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Menstrual Pain <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Nipple Discharge <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Painful Intercourse <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Painful Periods <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Premenstrual Syndrome <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> <input type="checkbox"/></p> <p>Date of last mammogram? / /</p> <p>MEN ONLY Current Past</p> <p><input type="checkbox"/> Erection Difficulties <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Lump in Testicles <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Penis Discharge <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Sore on Penis <input type="checkbox"/> <input type="checkbox"/></p> | <p>SEXUALLY TRANSMITTED DISEASES</p> <p><input type="checkbox"/> Specify: _____</p> <p><input type="checkbox"/> Specify: _____</p> <p>HEMAT/LYMPH Current Past</p> <p>Easy Bruising <input type="checkbox"/> <input type="checkbox"/></p> <p>Enlarged Lymph Nodes <input type="checkbox"/> <input type="checkbox"/></p> <p>LUNGS Current Past</p> <p>Cough <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty Breathing on Exertion <input type="checkbox"/> <input type="checkbox"/></p> <p>Shortness of Breath <input type="checkbox"/> <input type="checkbox"/></p> <p>Spitting up Blood <input type="checkbox"/> <input type="checkbox"/></p> <p>Wheezing <input type="checkbox"/> <input type="checkbox"/></p> <p>MS (Muscle/Joint/Bone) Current Past</p> <p>Change in Height <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty Walking <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> _____</p> <p>Pain, weakness, numbness in (area) _____</p> <p>SKIN Current Past</p> <p>Dry Skin <input type="checkbox"/> <input type="checkbox"/></p> <p>Moles <input type="checkbox"/> <input type="checkbox"/></p> <p>Rash <input type="checkbox"/> <input type="checkbox"/></p> <p>Sores That Do Not Heal <input type="checkbox"/> <input type="checkbox"/></p> <p>NEUROLOGIC Current Past</p> <p>Dizziness <input type="checkbox"/> <input type="checkbox"/></p> <p>Headaches <input type="checkbox"/> <input type="checkbox"/></p> <p>Memory Problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Numbness <input type="checkbox"/> <input type="checkbox"/></p> <p>Tremor <input type="checkbox"/> <input type="checkbox"/></p> <p>PSYCHIATRIC Current Past</p> <p>Anxiety <input type="checkbox"/> <input type="checkbox"/></p> <p>Depression <input type="checkbox"/> <input type="checkbox"/></p> |
|--|--|---|

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____ Reviewed By _____ Date _____