

**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

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>
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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 _____