

# Patient History

Today's date \_\_\_\_\_ Date of last Physical Exam \_\_\_\_\_

Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy name \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Referring Doctor \_\_\_\_\_

**Chief complaint:** (What is the main reason for today's visit)  
 \_\_\_\_\_  
 \_\_\_\_\_

**GENITOURINARY HISTORY:** (Please check those which apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Urine retention (unable to empty bladder) | <input type="checkbox"/> Nocturia (how many times to bathroom at night) _____ |
| <input type="checkbox"/> Kidney disease                            | <input type="checkbox"/> Urinary Incontinence (unable to control urine)       |
| <input type="checkbox"/> Pain with urination                       | <input type="checkbox"/> Impotence (unable to have an erection)               |
| <input type="checkbox"/> Burning with urination                    | <input type="checkbox"/> Kidney Stones (Last time) _____                      |
| <input type="checkbox"/> Frequency (frequent voiding)              | <input type="checkbox"/> Prostate surgery: _____                              |
| <input type="checkbox"/> Hesitancy (unable to start stream)        | <input type="checkbox"/> Bladder catheterizations: _____                      |
| <input type="checkbox"/> Hematuria (blood in urine)                | <input type="checkbox"/> IVP x-ray: _____                                     |
|  | <input type="checkbox"/> CT Scan of Abdomen belly) _____                      |

**Please list all drug allergies:** \_\_\_\_\_

**Medications:**

| Name | Dose | How Often |
|------|------|-----------|
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|      |      |           |
|      |      |           |
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**List any surgeries and serious hospitalizations.**

**Year or Age**

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**Past and present illnesses example (heart disease, diabetes, etc.)**

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