

SOCIAL HISTORY

PLEASE CIRCLE

OCCUPATION (RETIRED, FULL TIME, PART TIME) _____

MARITAL STATUS _____

NUMBER OF CHILDREN _____

ALCOHOL CONSUMPTION _____

TOBACCO USE (NOW OR IN THE PAST) _____

MOST RECENT PSA VALUE _____

REVIEW OF SYSTEMS (Circle all that apply)

CONSTITUTIONAL

FATIGUE/WEAKNESS Y N
 WEIGHT GAIN Y N
 WEIGHT LOSS Y N
 FEVER Y N
 CHILLS Y N

EYES / EARS / NOSE / THROAT

EYE PAIN Y N
 BLURRED VISION Y N
 SORE THROAT Y N
 SINUS PAIN Y N
 HEARING PROBLEMS Y N

NEUROLOGICAL

DIZZINESS Y N
 NUMBNESS Y N
 TREMORS Y N
 TINGLING Y N

RESPIRATORY

COUGH Y N
 WHEEZING Y N
 SHORTNESS OF BREATH Y N
 BLOOD IN SPUTUM Y N

CARDIOVASCULAR

PALPITATIONS Y N
 LEG PAIN WITH EXERTION Y N
 CHEST PAIN Y N
 ANKLE SWELLING Y N

GASTROINTESTINAL

ABDOMINAL PAIN Y N
 CONSTIPATION Y N
 DIARRHEA Y N
 NAUSEA Y N
 VOMITING Y N

HEMATOLOGICAL

EASY BRUISING Y N
 BLEEDING PROBLEM Y N

MUSCULOSKELETAL

NECK PAIN Y N
 JOINT PAIN Y N
 BACK PAIN Y N

SKIN

RASHES Y N
 ITCHING Y N
 SKIN INFECTIONS Y N

ENDOCRINE

SWOLLEN GLANDS Y N
 EXCESSIVE THIRST Y N
 HEAT/COLD TOLERANCE Y N

PSYCHIATRIC

DEPRESSION Y N
 ANXIETY Y N

UROLOGICAL PROBLEMS (Circle all that apply)

BURNING WITH URINATION Y N
 DIFFICULTY STARTING STREAM Y N
 URINATING AT NIGHT Y N
 INCONTINENCE Y N

SLOW URINARY STREAM Y N
 FREQUENT URINATION Y N
 BLOOD IN URINE Y N

 Signature of patient / patient representative

 Date signed

Wichita Urology Group, P.A.
MEDICAL HISTORY FORM

Patient Name _____ DOB _____ Age _____

Family Doctor _____ City _____ Referring Doctor _____

Other Doctors Caring For You _____

Reason For Visit/Chief Complaint _____

PATIENT PAST MEDICAL HISTORY

PLEASE COMPLETE FORM IN BLACK OR BLUE INK

HEENT (Circle all that apply)

Brain Tumor Y N
Cataract Y N
Stroke Y N
Eyesight Problems Y N
Hearing Loss Y N
Mouth Cancer Y N
Other Eye Disorder Y N
Other Ear/ Nose/ Throat Disorder Y N

LUNGS

Asthma Y N
Chronic Bronchitis Y N
COPD/Emphysema Y N
Lung Cancer Y N
Pneumonia Y N
Other Lung Problem Y N

URETER (Circle all that apply)

Abnormal Ureter Y N
Blocked Kidney Y N
Duplication of Ureter Y N
Ureteral Cancer Y N
Ureteral Stone Y N
Reflux of Urine Y N
Ureteral Disorder (not specified) Y N

BLADDER

Inability to Empty Bladder Y N
Bladder Stones Y N
Bladder Cancer Y N
Interstitial Cystitis Y N
Spastic Bladder Y N
Stress Incontinence Y N
Urge Incontinence Y N
Urinary Tract Infection Y N
Other Bladder Disorder Y N

HEART (Circle all that apply)

A-Fib Y N
Heart Attack Y N
Hardening of the Arteries Y N
Irregular Heartbeat Y N
Heart Valve Disease Y N
Other Heart Disorder Y N

VASCULAR

Aortic Aneurysm Y N
Hardening of Carotid Artery Y N
DVT (blood clot in legs) Y N
High Cholesterol Y N
High Blood Pressure Y N
PVD (narrowed arteries) Y N
Other Blood Vessel Problem Y N

LIVER/GALLBLADDER

Gallbladder Problem Y N
Cirrhosis Y N
Hepatitis Y N
Liver Cancer Y N
Pancreatitis Y N

PROSTATE (Circle all that apply)

Enlarged Prostate Y N
Prostate Stones Y N
Prostate Cancer Y N
Prostatitis Y N
Other Prostate Disorder Y N

URETHRA

Urethral Diverticulum Y N
Urethral Scar/Stricture Y N
Urethral Infection/Irritation Y N
Other Urethral Disorder Y N

KIDNEY (Circle all that apply)

Kidney Stone Y N
Kidney Infection Y N
Cyst of Kidney Y N
Kidney Cancer Y N
Other Kidney Problem Y N

GASTROINTESTINAL

Crohn's Disease Y N
Diverticulitis Y N
Diverticulosis Y N
GERD/Reflux Y N
Stomach Cancer Y N
Hemorrhoids Y N
Colon Cancer Y N
Peptic Ulcer Y N
Rectal Cancer Y N
Cancer of Small Intestine Y N
Other GI Disorder Y N

ORTHOPEDIC (Circle all that apply)

Back Pain Y N
Arthritis Y N
Spinal Stenosis Y N
Other Orthopedic Disorder Y N

NEUROLOGIC

Spina Bifida Y N
Cerebral Palsy Y N
Multiple Sclerosis Y N
Parkinson's Disease Y N
Spinal Cord Injury Y N
Stroke Y N
Other Neurologic Disorder Y N

PLEASE COMPLETE FORM IN BLACK OR BLUE INK

PATIENT PAST MEDICAL HISTORY CONTINUED

GYN

Cervical Cancer	Y	N
Falling Bladder (cystocele)	Y	N
Heavy Menses	Y	N
Ovarian Cancer	Y	N
Polycystic Ovary Syndrome	Y	N
Uterine Cancer	Y	N
Vaginal Enterocoele	Y	N
Rectocele (falling rectum)	Y	N
Vaginal Infection	Y	N
Other Gynecologic Disorder	Y	N

ENDOCRINE

Adrenal Disorders	Y	N
Diabetes	Y	N
Thyroid Disorders	Y	N
Other Endocrine Disorder	Y	N

Sexually Transmitted Disease Y N

Past Medical History
(Not otherwise specified)

LIST ALL PRIOR SURGERIES AND DATE

LIST CURRENT MEDICATIONS AND DOSAGES

(INCLUDE OVER-THE-COUNTER MEDICATIONS AND HERBS)

LIST MEDICATION ALLERGIES AND TYPE OF REACTION

ANY REACTION TO IODINE? TYPE OF REACTION

FAMILY HISTORY

(IF EITHER PARENT IS DECEASED, LIST CAUSE OF DEATH)

DO YOU HAVE A FAMILY HISTORY OF: (CIRCLE ALL THAT APPLY)

BLADDER CANCER	PROSTATE CANCER	KIDNEY CANCER	HEART ATTACK
STROKE	KIDNEY DISEASE	DIABETES	OTHER _____