AUSTIN UROLOGY
INSTITUTE

Patient History Form

Name: First _____ Last _____ DOB: _____

Reason for visit: _____

Pharmacy/Location: _____

Referring physician/Primary Care: _____

Medication allergies: _____

Medications: (please list name and dosage or attach list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History: Please list IMMEDIATE family only (parents, siblings, and grandparents)

Heart disease / stroke / high blood pressure: Yes/No relation: _____

Diabetes: Yes/No relation: _____

Breast Cancer: Yes/No relation: _____

Prostate Cancer: Yes/No relation: _____

Prolapse (female): Yes/No relation: _____

Kidney Stones: Yes/No relation: _____

Social History:

65yrs+ Do you have an Advance Directive (living will)? Yes/No If yes, where is it on file? _____

Alcohol intake:	None	Occasional	Moderate	Heavy
Caffeine intake:	None	Occasional	Moderate	Heavy
Exercise level:	None	Occasional	Moderate	Heavy

Marital Status: S M D other _____

What is your occupation: _____

Sexually active: Yes/No

Smoking status:	Never	Former	Everyday	Someday

65yrs+ Colorectal Screening: Colonoscopy Yes/No When? _____

Surgical History (please list): Year of procedure

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Past Medical History (please circle all that apply)

Anxiety	Fibromyalgia	Reflux
Arthritis	Blood in Urine	Thyroid
Asthma	High Cholesterol	Enlarged Prostate
Cancer	High Blood Pressure	Erectile Dysfunction
Heart History	Kidney Stones	Other _____
Depression	Migraines	_____
Diabetes	Obesity	_____

Females only: Please list your pregnancy history:

Type of delivery (vag/c-sec)	Year of delivery
_____	_____
_____	_____
_____	_____

Please **circle** all that apply **CURRENTLY:**

General:	Excess weight gain	Excess weight loss	Fever	
Eyes:	Blurry Vision	Double Vision		
Ears/Nose/Throat:	Ear pain	Sore throat	Problems swallowing	
Cardiovascular:	Chest pain	Palpitations	Rapid heart rate	
Respiratory:	Cough	Wheezing	Chest tightness	
Gastrointestinal:	Nausea	Vomiting	Diarrhea	Change in appetite
Genitourinary:	Discharge	Blood in urine	Pain with urination	
	Voiding Frequency	Voiding urgency	Testicular pain	
	Swelling	Redness	Itching	Masses
Hematologic/Lymphatic:	Easy bruising	Swollen glands		
Musculoskeletal:	Joint pain	Back pain		
Skin:	Rashes	Discoloration		
Neurologic:	Headache	Dizziness	Loss of consciousness (fainting)	
Psychological:	Nervousness	Depression	Insomnia	
Endocrine:	Temperature intolerance (cold, hot)	Increased thirst	Excessive sweating	
Allergic/Immunologic:	Food Allergies	Other allergies: _____		