

# NORTHSTAR UROLOGY PATIENT HISTORY FORM

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date \_\_\_\_\_ Age \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

### Chief Complaint

What is the main reason for your visit today? (describe in detail) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### History of Present Illness

When did this problem start? \_\_\_\_\_

When it occurs, how long does it last? \_\_\_\_\_

Is the problem constant or does it come and go? \_\_\_\_\_

Where is the location of this problem? \_\_\_\_\_

Are there other symptoms occurring at the same time (ie. Nausea, vomiting...) \_\_\_\_\_

What treatments have you tried? \_\_\_\_\_

Have they worked? \_\_\_\_\_

If there is discomfort, where is it? \_\_\_\_\_

Are there any associated issues? \_\_\_\_\_

### Have you had any of the following...

Blood in the urine  YES  NO Urinary tract cancer  YES  NO

Pain with urination  YES  NO Urinary tract surgery  YES  NO

Incontinence or leakage or urine  YES  NO Sexually trans. disease  YES  NO

If yes, do you wear pads or diapers? \_\_\_\_\_ Abdominal pain  YES  NO

If yes, how many daily? \_\_\_\_\_ Back pain  YES  NO

Erectile dysfunction or curvature?  YES  NO Fevers / chills  YES  NO

Urinary tract infections (bladder or kidney)?  YES  NO Nausea / vomiting  YES  NO

Kidney stones  YES  NO Diarrhea / constipation  YES  NO

Physician Use Only

AUA Symptom Score \_\_\_\_\_

**Past Medical and Surgical History**

Please check "yes" or "no"

- |                     |                              |                             |                          |                              |                             |
|---------------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|
| Heart disease       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Lung disease             | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Heart attack        | <input type="checkbox"/> YES | <input type="checkbox"/> NO | (asthma, COPD, etc.)     |                              |                             |
| High blood pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Liver disease            | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes            | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Kidney disease           | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Stroke              | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Bleeding/clotting issues | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

If yes, please explain

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Please list any other medical problems \_\_\_\_\_

Please list any surgery that you have had, including childhood \_\_\_\_\_

**Medication and Allergies**

Do you have any allergies to medications? \_\_\_\_\_

Please list all medications, including vitamins, supplements, and herbal remedies \_\_\_\_\_

Do you take aspirin?  YES  NO

**Family History**

Father: Age: \_\_\_\_\_ Living?  YES  NO Medical Problems? \_\_\_\_\_

Mother: Age: \_\_\_\_\_ Living?  YES  NO Medical Problems? \_\_\_\_\_

Siblings: Number of sisters \_\_\_\_\_ Medical Problems? \_\_\_\_\_

Number of brothers \_\_\_\_\_ Medical Problems? \_\_\_\_\_

Family history of prostate cancer? \_\_\_\_\_

Family history of heart disease? \_\_\_\_\_

**Social History**

What type of work do you do? \_\_\_\_\_

Do you currently smoke?  YES  NO For how long? \_\_\_\_\_

Have you ever smoked?  YES  NO For how long? \_\_\_\_\_

Do you drink alcohol?  YES  NO How many drinks per week? \_\_\_\_\_

Do you use drugs?  YES  NO If so, what? \_\_\_\_\_

**Review of Systems**

Do you have any of the following? If yes, please explain answers in margin.

**Constitutional**

- Fevers  YES  NO
- Weight loss  YES  NO

**Vision**

- Blurred vision  YES  NO
- Temporary blindness in one eye  YES  NO

**Ear/Nose/Throat**

- Deafness  YES  NO
- Swollen Lymph Nodes  YES  NO

**Respiratory**

- Shortness of breath  YES  NO
- Chronic Cough  YES  NO

**Cardiovascular**

- Chest pain  YES  NO
- Palpitations  YES  NO

**Gastrointestinal**

- Vomiting  YES  NO
- Abdominal pain  YES  NO

**Musculoskeletal**

- Joint pain  YES  NO
- Muscle aches  YES  NO

**Neurological**

- Dizziness  YES  NO
- Fainting  YES  NO

**Skin**

- Rashes/Lesions  YES  NO
- Itching  YES  NO

**Endocrine**

- Excessive thirst  YES  NO
- Too hot/cold  YES  NO

**Lymphatic**

- Swollen glands  YES  NO
- new lumps  YES  NO

**Other** \_\_\_\_\_  
\_\_\_\_\_

Assessment / Plan

At least \_\_\_\_\_ minutes of time was spent face to face with the patient with >50% discussing treatment options / coordination of care as noted above, or as documented in dictated visit note.

Total Time \_\_\_\_\_ Counseling/Coordination of Care \_\_\_\_\_

Physician Signature

Date

Time

Dictation Number \_\_\_\_\_