Northwest Urology LLC

Medical History for Date:_____

Patient Name: _____ Date of Birth: _____

The reason for your visit: _____

Past Medical History (Circle **Y**es or **N**o. If **Y**es, please explain):

Bleeding Disorder	Y N	_____	**Heart Disease**	Y N	_____
Cancer	Y N	_____	**High Blood Pressure**	Y N	_____
Chemo/Radiation	Y N	_____	**Lung Problems**	Y N	_____
Claustrophobia	Y N	_____	**Metal in your body**	Y N	_____
Diabetes	Y N	_____	**Neurologic (Parkinson's, MS)**	Y N	_____
Enlarged Prostate	Y N	_____	**Stroke**	Y N	_____

Have you received the Pneumonia Vaccine? Y N Date: _____ **Flu Shot** Y N Date: _____

Have you fallen in the past year? ☐ No falls or 1 fall without injury ☐ 2+ falls or any fall with injury

Have you had a Sigmoidoscopy Y N Colonoscopy Y N Date: _____

Other: _____

FOR WOMEN

Day of Last Menstrual Period		_____	**Number of Deliveries**		_____
Number of Pregnancies		_____	**Currently Pregnant?**	Y N	Due Date: _____
Mammogram	Y N	Date: _____	**Pap Smear**	Y N	Date: _____

Past Surgical History (Circle **Y**es or **N**o. If **Y**es, please explain):

FOR MEN			*FOR WOMEN*		
Bladder	Y N	_____	**Bladder**	Y N	_____
Kidney	Y N	_____	**Caesarean Section**	Y N	_____
Prostate	Y N	_____	**Hysterectomy**	Y N	_____
Vasectomy	Y N	_____	**Kidney**	Y N	_____
			Tubal Ligation	Y N	_____

Other: _____

List all **MEDICATIONS** and **DOSAGES** you are **CURRENTLY** taking including Over-the-Counter and Supplements:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

(continued on back)

Do you have any **ALLERGIES** to the following: (Circle **Y**es or **N**o. If **Y**es, please explain)

Medications Y N _____ **Latex** Y N _____

Betadine Y N _____ **Other** Y N _____

Social History (Circle **Y**es or **N**o. If **Y**es, please explain):

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Partner

Have you ever used tobacco products? Y N How often/how long? _____

Do you currently smoke cigarettes? Y N How often/how long? _____

Do you ever drink alcohol? Y N How often/how long? _____

Do you ever use recreational drugs? Y N How often/how long? _____

Family History

Does anyone in your **FAMILY** have a **HISTORY** of the following? (Circle **Y**es or **N**o. If **Y**es, please explain)

Diabetes Y N _____ **Prostate Cancer** Y N _____

Heart Disease Y N _____ **Kidney/Bladder Cancer** Y N _____

Kidney Disease Y N _____ **Kidney Stones** Y N _____

Other: _____

Are you **CURRENTLY** experiencing any of the following:

Constitutional Problems:
- Fevers/Chills No Yes
- Low Energy No Yes
- Other: _____

Cardiac (Heart) Problems:
- Chest Pain No Yes
- Other: _____

Respiratory Problems:
- Shortness of Breath No Yes
- Other: _____

Gastrointestinal Problems:
- Abdominal Pain No Yes
- Nausea/Vomiting No Yes
- Other: _____

Skin Problems:
- Genital Lesion(s) No Yes
- Other: _____

Psychiatric Problems:
- Depression No Yes
- Anxiety No Yes
- Other: _____

Endocrine Problems:
- Increased Thirst or Appetite No Yes
- Other: _____

Neurologic Problems:
- Dizziness No Yes
- Lightheadedness No Yes
- Other: _____

Hematologic/Lymphatic Problems:
- Swollen Glands No Yes
- Other: _____

Musculoskeletal Problems:
- Back Pain No Yes
- Other: _____

Genitourinary Problems:
- Blood in Urine No Yes
- Pain During Urination No Yes
- Other: _____