SouthWest Urology
Advanced & Personalized Treatment For Your Entire Family

HEALTH HISTORY

Patient Name_____ Today's Date_____

Age:_____ Birthdate:_____

MAIL ORDER PHARMACY NAME/ADDRESS/PHONE:

_____

Phone:_____

LOCAL PHARMACY NAME/ADDRESS/PHONE:

_____

Phone: _____

Allergies? (Circle) **Yes** (if yes, please list below) or **No**

_____

_____

Medication List

Please list all medications: Prescription/over the counter/vitamins/supplements
List dosage and how often you take *Example: Flomax 0.4 mg 1 tablet a day*

	Name	Dose	How often per Day?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Surgical History

List all Surgery from childhood to present including year of surgery. Example: Tonsils removed 1989

1._____
2._____
3._____
4._____
5._____
6._____
7._____

(OVER)

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Patient Name_____ Today's Date_____

SYMPTOMS: Check (√) symptoms you currently have or have had in the past year.			
CONSTITUTIONAL	**EYES**	**EARS, NOSE, MOUTH, THROAT**	**CARDIOVASCULAR**
□ Fever	□ Blurry Vision	□ Hearing Loss	□ Chest Pain
□ Chills	□ Double Vision	□ Nasal Stuffiness	□ Swollen Ankles
□ Weight Loss	□ Cataracts	□ Sore Throat	□ Irregular Heartbeat
□ Fainting			
RESPIRATORY	**GASTROINTESTINAL**	**GENITOURINARY**	**MUSCULOSKELETAL**
□ Shortness of Breath	□ Abdominal Pain	□ Incontinence	□ Chronic Back Pain
□ Wheezing	□ Nausea/Vomiting	□ Painful Urination	□ Chronic Neck Pain
□ Chronic Cough	□ Change in Bowels	□ Blood in Urine	□ Sore Muscles
INTEGUMENTARY/ SKIN	**NEUROLOGICAL**	**HEMATOLOGIC/ LYMPHATIC**	
□ Rash	□ Numbness	□ Swollen Glands	
□ Persistent Itching	□ Tingling	□ Abnormal Bleeding	
□ Skin Cancer History	□ Dizziness	□ Transfusion History	

CONDITIONS: Check (√) conditions you have or have had in the past.			
□ AIDS	□ Constipation	□ Hearing Loss Aide?	□ Prostate Problem
□ Alcoholism	□ Coronary Artery Bypass	□ Heart Arrhythmia	□ Pulmonary Embolus
□ Anemia	□ Depression	□ Hepatitis A B C	□ Seizures
□ Anorexia	□ Dementia	□ Hernia- Umbilical	□ Sleep Apnea
□ Appendicitis	□ Diabetes	□ Hernia- Inguinal R L	□ Stroke: CVA TIA
□ Arthritis	□ Dialysis	□ High Blood Pressure	□ Suicide Attempt
□ Asthma	□ Diverticulitis	□ High Cholesterol	□ Thyroid Problems
□ Atrial Fibrillation	□ Emphysema	□ Kidney Failure	□ Tonsillitis
□ Bleeding Disorders	□ Epilepsy	□ Liver Disease	□ Tuberculosis
□ Breast Lump	□ Fibromyalgia	□ Measles	□ Ulcers
□ Bronchitis	□ GERD	□ Migraine Headaches	□ Vaginal Infections
□ Bulimia	□ Glaucoma	□ Miscarriage	□ Venereal Disease: Gonorrhea HPV Herpes Syphilis
□ Cancer (type)	□ Goiter	□ Mononucleosis	
□ Cataracts	□ Gout	□ Multiple Sclerosis	
□ Chemical Dependency	□ Heart Valve Prolapse	□ Pacemaker	**Date of Last Colonoscopy:**
□ Crohn's Disease	□ Heart Valve Replaced	□ Parkinson's	□ **Pneumonia Vaccine** □ YES □ NO Date: _____
□ COPD	□ Heart Disease	□ Pneumonia	
□ Congestive Heart Failure	□ Heart Stents	□ Polio	

SOCIAL HISTORY

Marital Status : (circle) Married Single Divorced Widowed Legally Separated Annulled Life Partner

Smoking Status: (circle) Current Every Day Current Some Day Former Smoker Never Smoker

Date started: _____ How many packs a day? _____ Date quit: _____

Smokeless Tobacco □ Yes □ No

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Do you drink Alcohol? (circle) Yes No Never If yes, How much do you drink? ____ per day week month year What type of alcohol do you consume? Beer Liquor Wine Drinking habits: Social Light Moderate Excessive If not anymore, when did you quit drinking? _____
Do you use Recreational Drugs? (circle) Yes No
How many caffeinated drinks do you have each day? 0 1 2 3 4+
Have you had a Blood Transfusion? (circle) Yes No
Race: (circle) White Black or African American Indian Hispanic Eskimo Native Alaskan Asian Hispanic or Latino Native Hawaiian or other pacific Islander
Language Spoken: (circle) English Spanish French German Portuguese Russian Chinese Japanese Italian Vietnamese Arabic Declined to answer
Ethnicity: (circle) Hispanic or Latino Non-Hispanic Unknown Declined to answer
Current or Former Occupation?

FAMILY HISTORY

DISEASE	√	Check if **your blood relatives** had any of the following. Enter relationship: **mother, father, sister, brother, aunt, uncle, grand parent, etc**.
Arthritis		
Asthma		
Bladder Cancer		
Cancer (Type)		
Chemical Dependency		
COPD		
Dementia/Alzheimer		
Diabetes		
Gout		
Hay Fever		
Heart Disease		
High Blood pressure		
Kidney Disease		
Prostate Cancer		
Stroke		
Testicular Cancer		
Tuberculosis		