SouthWest Urology
Advanced & Personalized Treatment For Your Entire Family

MRN ____________

Health History

Patient Name__________________________ DOB____/______/_______ Today's Date___________________

Pharmacy

Mail order:________________________ Phone (   )____________________ ID #________________________

Local Pharmacy: _______________________________ Phone (   ) __________________

Allergy

List all if the allergies you have, including **latex**

□ No known drug allergies. Allergic to ________________________________

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

□ Not currently taking medications

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

Surgical and Hospital

List all surgeries and/or hospitalizations that you have had and the year in which they occurred.

□ No past surgeries   □ No past hospitalizations

Surgery or Hospital Details	Date	Surgery or Hospital Details	Date
1.________________________	__/___/___	2. ____________________	_____/____/_____
3.________________________	__/___/__	4.____________________	_____/____/_____
5.________________________	__/___/___	6.____________________	__/_____/_____
7. ________________________	__/___/___	8.____________________	__/_____/_____

HealthHistory Rev. 04/29/2019sg

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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 C-PAP Yes or No
☐ 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	

MRN ___________

Patient Name____ Today's Date___________________

Family History

List history of cancer, stone disease, heart disease, or other serious health issues.

Family member	Medical Condition
______________	____
______________	____
______________	____
______________	____

Social History

Tobacco Use Recreational Drug Use

☐ Never smoked

☐ Every day/ Occasional smoker
Packs Per Day ____
Years Smoked ____

☐ Former smoker
Packs Per Day ____
Years Smoked ____
Date Quit ____

Recreational Drug use

☐ Yes Type _____________
☐ No

Alcohol Use

☐ Never drinks

☐ Every day/Occasional drinker
Type ______________

☐ Former drinker
Type ______________
Date quit_________

Sexually Active

☐ Yes
☐ No

How many caffeinated drinks do you have each day?

_________ daily

Have you had a Blood Transfusion?

☐ 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