NORTH DFW UROLOGY, LLP
1601 Lancaster Drive Suite 170 Grapevine, TX 76051

HEALTH HISTORY FORM

Date: _____ Patient: _____ DOB: _____ Age: _____

PAST MEDICAL HISTORY
Please check ALL applicable
___ NO MEDICAL PROBLEMS

___ Alzheimer's Disease
___ Anemia
___ Anxiety
___ Asthma
___ ADHD
___ Bleeding Problems
___ Blood clot in lungs
___ Blood clot in leg
___ Cancer _____
___ Cardiovascular Disease
___ Chicken Pox
___ Claustrophobia
___ Congestive Heart Failure
___ Convulsions
___ COPD
___ Depression
___ Diabetes I
___ Diabetes II
___ Drug Dependency
___ Emphysema
___ Enlarged Prostate
___ Epilepsy / Seizures
___ Fibromyalgia
___ Gallbladder
___ GERD
___ Gout
___ Heart Attack – When? _____
___ Heart Failure
___ Hepatitis – What type? A B C
___ High Blood Pressure
___ HIV / AIDS
___ Thyroid Disease (Hypothyroidism, Hyperthyroidism)
___ Intestinal Problems
___ Kidney Stones (____Right side ____Left side)
___ Lupus / Immune Disease
___ Osteopenia
___ Osteoporosis
___ Other _____
___ Pneumonia
___ Psoriasis
___ Psychiatric Problems
___ Renal Failure
___ Rheumatoid Arthritis
___ Scoliosis
___ Stroke / TIA's
___ Ulcers

ENVIRONMENTAL Allergies
___ None
___ Adhesives
___ Latex
___ Other _____

DRUG Allergies
___ No Drug Allergies
___ _____
___ _____
___ _____

FOOD Allergies
___ None
___ Peanuts
___ Shell Fish
___ Other _____

MEDICATIONS
___ I take NO Medications ___ I take the following Medications

Name of Medication	Dosage	Date Started	Who Prescribed

PAST SURGICAL HISTORY
Please list any prior surgeries

Surgery	Surgeon	Date	Body Part

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HEALTH HISTORY FORM – page 2

Date: _____ Patient: _____ DOB: _____

GASTROURINARY

Main Complaint: _____

- When did it start? _____ How long does the problem last? __30 min __ 1 hour __ Always there
- Does anything help or make problem worse? __ Y __N What? _____
- Is there anything else occurring at the same time? __ Y __ N What? _____
- Is problem __Constant or __ Variable?

___ Frequency – How Often? _____
___ Burning upon urination
___ Pain (___ Back ___ Lower Abdominal)
___ Straining to urinate
___ Feeling of incomplete emptying of bladder after urination
___ Leakage after coughing, sneezing or physical activity
___ Feeling urge to urinate but unable to do so
___ Discharge from Penis
___ Sexual Problems – if so what kind and for how long? _____

___ Blood in Urine
___ Getting up at night to urinate, if so how many times? _____
___ History of bedwetting
___ Dribbling of urine after urination
___ Discharge from Vagina
___ Slowness of urinary stream
___ Pain in testicles

FAMILY MEDICAL HISTORY

Family History of:	Relationship
___ Adopted	_____
___ NO family history	_____
___ Arthritis	_____
___ Bleeding Problems	_____
___ Blood Clotting Problems	_____
___ Cancer-Prostate	_____
___ Cancer-Kidney	_____
___ Cancer-Bladder	_____
___ Cancer – Testicular	_____
___ Crohn's Disease	_____
___ Diabetes	_____

Family History of:	Relationship
___ Epilepsy	_____
___ Heart Disease	_____
___ Hematuria	_____
___ High Cholesterol	_____
___ Hypertension	_____
___ Kidney Stones	_____
___ Recurrent UTI	_____
___ Stroke	_____
___ Other:	
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Marital Status
___ Married
___ Divorced
___ Separated
___ Single
___ Widowed
___ Other _____
___ Spouse Name _____

Work Status
___ Disabled
___ Homemaker
___ Retired
___Student
___ Unemployed
___ Work PT
___ Work FT

Substance Use
___ Tobacco
___Former ___Packs/day _____ When Stopped?
___Current ___Packs/day
___Never Smoked
___ Social Drinker ____ Drinks/week
___ Moderate Drinker ___Drinks/week
___ Heavy Drinker _____Drinks/week
___ Never Drank
___ Former Drinker _____ When Stopped?
___ Alcoholism
___ Illicit Drugs

Do you drink caffeinated drinks? __ Y __ N What type? _____ How many each day? _____
Have you ever had a Blood Transfusion? ___ Y ___ N if yes, date_____
Have you ever had anesthesia? __ Y ___N Any problems? _____

Occupation or former occupation if retired: _____