UROLOGY CENTER OF FLORIDA PATIENT HISTORY

Patient____ Date________________________ Age________

Dear Patient,

Welcome to the Urology Center of Florida. We are committed to providing you with the best and most experienced leading-edge care. You will find that our staff is friendly and helpful and your diagnosis and treatment will be done in a confidential and comfortable setting. Please fill this form out **COMPLETELY** so we may best be able to provide excellent service to you. Please note that there are TWO pages to this form.

1. Chief Complaint: (Reason for visit, describe in detail including duration of problem)

2. List all past and present medical conditions and surgeries with dates:

3. List all prescription and non prescription medications, including herbal preparations. Please include dosages and your local PHARMACY with phone number if you have one. If necessary, we may serve you better by calling in your prescriptions if the need arises. Also, please indicate if you take Coumadin, Aspirin, Plavix, or Vitamin E.

4. List all allergies to medications and describe the type of reaction as well as the year the reaction occurred.

PLEASE CIRCLE THE APPROPRIATE RESPONSE TO THE FOLLOWING QUESTIONS 5 – 10 and explain.

5. Are you on a special diet? YES or NO If yes, please describe. ______________________

6. Do you smoke? YES or NO If yes, how much? ______________________

7. Do you drink? YES or NO If yes, how much? ______________________

8. Do you require antibiotic prophylaxis before going to the dentist? YES or NO______________________

9. Do you require a wheelchair, walker, or cane? YES or NO ______________________

10. Do you have a pacemaker or defibrillator? YES or NO______________________

11. Do you now have or have you ever had any of these problems? Please circle YES or NO next to every possible complaint and please explain every YES answer.

Body System	Specific Symptoms	YES OR NO	EXPLANATION OF YES ANSWER
General Symptoms	Chronic Fever	YES or NO	
	Chronic Headache	YES or NO	
	Weight Loss	YES or NO	
	Weight Gain	YES or NO	
Eyes	Double or Blurred Vision	YES or NO	

Body System	Specific Symptoms	YES or NO	EXPLANATION OF YES ANSWER
Respiratory	Wheezing	YES or NO	
	Frequent Cough	YES or NO	
	Shortness of Breath	YES or NO	
Neurological	Tremors	YES or NO	
	Stroke or TIA	YES or NO	
	Dizzy Spells	YES or NO	
	Numbness/Tingling	YES or NO	
Endocrine	Diabetes	YES or NO	
	Thyroid	YES or NO	
	Too Hot/Too Cold	YES or NO	
	Tired/Sluggish	YES or NO	
Gastrointestinal	Abdominal Pain	YES or NO	
	Nausea/Vomiting	YES or NO	
	Indigestion/Heartburn	YES or NO	
Cardiovascular	Chest Pain	YES or NO	
	Varicose Veins	YES or NO	
	High Blood Pressure	YES or NO	
	Mitral Valve Prolapse/or Valvular Disease	YES or NO	
Integumentary	Skin Rash or Persistent Itching	YES or NO	
Musculoskeletal	Joint Pain (please specify which joints)	YES or NO	
	Neck Pain	YES or NO	
	Back Pain	YES or NO	
Ear/Nose/ Mouth/Throat	Ear Infection	YES or NO	
	Nasal Problems	YES or NO	
	Sore Throat	YES or NO	
	Sinus Problems	YES or NO	
Hematological/ Lymphatic	Swollen Glands	YES or NO	
	Blood Clotting Problems	YES or NO	
Psycho/sexual	Are you satisfied with your life?	YES or NO	
	Do you feel SEVERLY depressed?	YES or NO	
	Have you considered suicide?	YES or NO	
	Sexually Transmitted Diseases	YES or NO	
	HIV/AIDS	YES or NO	

Patient Signature______________________________ Primary Care Physician______________________________