GRANGER MEDICAL CLINIC | *Summit Urology*

Patient History Form

Note: This is a confidential record and will be kept in our office. This information will not be released without your authorization.

Name:____ Today's date ______________ Marital status: M S W D

Who sent you to our office?____

What is your main problem today? ____

Local pharmacy ______________________________ Mail order pharmacy _________________________________

Past Medical & Social History

List all your surgeries and when they occurred.

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List all your serious illnesses and injuries and when they occurred.

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List all medications (and dosage) you are currently taking:

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Are you allergic to any medications? Yes No Please list all drug allergies: _____________________

Do you smoke now? Y N If yes, how many packs per day? _________ How many years?__________

Have you been a smoker in the past? Y N

How many years ago did you quit? ____________________How many years did you smoke? ________________

Do you drink alcohol? Y N If yes, how often do you drink?____

What is your occupation?_____________________ If retired, what was your occupation?___________________

Family History Information

List all serious illnesses in your immediate family. (Examples: diabetes, prostate cancer, heath disease, etc.)

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Review of Systems

Do you now have now or have you had any problems related to the following system
Please explain any YES answers in the space provided.

General

Fever	Y	N
Chills	Y	N
Night Sweats	Y	N
Other		

Skin

Bruising	Y	N
New Lesions	Y	N
Rash	Y	N
Other ______________________		

HEENT

Headache	Y	N
Visual Disturbances	Y	N
Seasonal Allergies	Y	N
Other ______________________		

Neck

Neck Mass	Y	N
Neck Pain	Y	N
Swollen Glands	Y	N
Other ______________________		

Respiratory

Chronic Cough	Y	N
Snoring	Y	N
Difficulty Breathing	Y	N
Other ______________________		

Breast

Breast Pain	Y	N
Gynecomastia	Y	N
Skin Changes	Y	N
Other ______________________		

Cardiovascular

Chest Pain	Y	N
Irregular Heart Beat	Y	N
Swelling of Extremities	Y	N
Other ______________________		

Gastrointestinal

Abdominal Pain	Y	N
Constipation	Y	N
Rectal bleeding	Y	N
Other ______________________		

Genitourinary

Blood in Urine	Y	N	
Urinary Frequency	Y	N	
Urinary Retention	Y	N	
Urinary infections	Y	N	
Slow urine stream-no force	Y	N	
Urinary Urgency	Y	N	
Bedwetting	Y	N	
Pressure over your bladder	Y	N	
Burning or hurting urination	Y	N	
Trouble starting urine flow	Y	N	
Get up at night to urinate	Y	N	
Urinary leakage with cough/sneeze	Y	N	
Constant urinary dribbling	Y	N	
Kidney stones	Y	N	
Prostate problems/infection	Y	N	NA
Problems with erections	Y	N	NA
Other ______________________			

Musculoskeletal

Back Pain	Y	N
Calf Pain	Y	N
Joint Pain	Y	N
Other ______________________		

Neurological

Numbness	Y	N
Stroke	Y	N
Weakness	Y	N
Other ______________________		

Psychiatric

Anxiety	Y	N
Change in Sleep Pattern	Y	N
Suicidal Planning	Y	N
Other ______________________		

Endocrine

Cold Intolerance	Y	N
Excessive Thirst	Y	N
Libido Change	Y	N
Other ______________________		

Hematology

Blood Clots	Y	N
Enlarged Lymph Nodes	Y	N
Prolonged Bleeding	Y	N
Other ______________________		