Central Wyoming Urological Associates
Helping You With Your Urological Needs

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Patient Health History Form

Patient Name _____ Date of Birth _____/_____/_____
Age _____ Height _____ Weight _____ Today's Date _____/_____/_____

Present Illness

Concerns or Reason for Today's Visit? _____
Location of problem (abdomen, flank, etc.) _____
Describe the problem _____
Severity of problem (scale of 1-10) _____ When did you first notice the problem? _____
How long does the problem last? _____
Is the problem constant or variable? Related to anything else? _____
Does anything else occur at the same time (nausea, fevers, etc.) _____
Does the problem interfere with your normal function? _____

Gynecological History (if female)

How many times have you been pregnant? _____ Given birth? _____ How many of your deliveries were vaginal? _____

Medical Conditions Please check the appropriate box if you have or have had any of the following

□ Diabetes □ Stroke/TIA □ Gall Stones □ Osteoporosis □ High Blood Pressure □ Seizures □ Hepatitis □ Arthritis
□ High Cholesterol □ Emphysema □ Kidney Stones □ Multiple Sclerosis □ Heart Disease □ Asthma □ Hypothyroidism
□ Heart Attack □ Acid Reflux □ Glaucoma □ Blood Clots □ Atrial Fibrillation □ Ulcers □ Gout □ Erectile Dysfunction
□ Cancer _____ □ Other _____

Medications Please list all of the medications you are currently taking. Include over-the-counter medications, herbs, and vitamins.

Medication Name	Dose & Frequency	Last Taken

Allergies Please list all allergies. State "none" if you do not have any allergies

Prior Surgeries

Procedure	Date Performed	Facility, City, State

Social History Please answer the following

Have you ever smoked cigarettes? □ No □ Yes, year started _____- stopped _____ Packs per day _____

Do you use chewing tobacco? □ No □ Yes, cans per day _____

Do you drink caffeine? □ No □ Yes, how much & what kind (coffee, soda, etc.) _____

How many times in the past year have you had 4 or more drinks containing alcohol in a day? _____

Average drinks per day _____ Did you ever drink heavily in the past? _____

Do you now use, or have you ever used, anabolic steroids? □ Yes □ No

Have you ever had a problem with addiction to prescription pain medication or benzodiazepines (like Valium, Xanax, etc.)?

□ No □ Yes, please explain_____

Do you now use, or have you ever used, drugs for recreational purposes? □ No □ Yes, check all that apply and give approximate dates used: □ Amphetamines_____□ Cocaine_____□ Heroin_____□ LSD_____

□ Marijuana_____□ Inhalants_____□ Other_____

Additional Urologic History

Are you circumcised? □ No □ Yes

Have you ever had kidney X-Rays (IVP, CT, etc) or Ultrasounds? □ No □ Yes, what hospital/facility took the images?

_____

Have you ever had a cystoscopic exam (look with a telescope in the bladder)? □ No □ Yes, indicate results, locations, and dates:

_____

If male, have you ever had a PSA test (blood test for prostate cancer screening)? □ No □ Yes, where & what were the results?

_____

Do you have urinary leakage? □ No □ Yes, # of protective pads used per day? _____

Is your leakage preceded by an urgent sensation to urinate? □ No □ Yes

Is your leakage preceded by coughs, sneezes, laughing, or other straining? □ No □ Yes

Do you have a history of bladder cancer and/or prostate cancer? □ No □ Yes, diagnosis facility location/provider?

_____

Family Medical History Please list any diseases or conditions identified in your immediate family (blood relatives)

Disease/Medical Condition	Relation (example: mother, father, son, daughter, etc.)