



# Lubbock Urology Clinic, L.L.P.

## PATIENT HISTORY

Name: \_\_\_\_\_ SSN# \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Cardiologist: \_\_\_\_\_

Why are you seeing the doctor today? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

What improves or worsens the problem/pain? \_\_\_\_\_

Are there any symptoms that go along with the problem/pain? \_\_\_\_\_

Is the problem/pain continuous or does it come and go? \_\_\_\_\_

Describe the pain if you have pain (sharp/dull, etc.) \_\_\_\_\_

Have you tried any medicine/treatment for this problem/pain? \_\_\_\_\_

### PAST MEDICAL HISTORY

Please mark (X) if you have or have had any of the following diseases or conditions:

#### CARDIOVASCULAR:

- \_\_\_ Anemia
- \_\_\_ Angina
- \_\_\_ Anorexia
- \_\_\_ Aortic Aneurysm
- \_\_\_ Aortic Insufficiency
- \_\_\_ Aortic Stenosis
- \_\_\_ Arrhythmia
- \_\_\_ Atrial Fibrillation
- \_\_\_ Bleeding Disorder
- \_\_\_ Cerebrovascular Disease
- \_\_\_ Congenital Heart Disease
- \_\_\_ Congestive Heart Failure
- \_\_\_ Deep Vein Thrombosis
- \_\_\_ Enlarged Heart
- \_\_\_ Heart Attack
- \_\_\_ Heart Disease
- \_\_\_ Heart Murmur
- \_\_\_ Heart Valve Problem
- \_\_\_ Hemophilia
- \_\_\_ Hypertension
- \_\_\_ Leukemia
- \_\_\_ Mitral Insufficiency
- \_\_\_ Mitral Stenosis
- \_\_\_ Rheumatic Fever
- \_\_\_ Sickle Cell Anemia
- \_\_\_ Stroke
- \_\_\_ Other: \_\_\_\_\_

#### ENDOCRINE/METABOLIC:

- \_\_\_ Diabetes Mellitus- (non-insulin dependent)
- \_\_\_ Diabetes Mellitus- (insulin dependent)
- \_\_\_ Diabetes Mellitus- (uncontrolled)
- \_\_\_ Goiter
- \_\_\_ Gout
- \_\_\_ Hyperthyroidism
- \_\_\_ Impaired Glucose Tolerance
- \_\_\_ Other: \_\_\_\_\_

#### GENERAL:

- \_\_\_ Allergies
- \_\_\_ Hepatitis \_\_\_
- \_\_\_ High Cholesterol
- \_\_\_ Infectious Disease
- \_\_\_ Lipid Disorder
- \_\_\_ Malaise
- \_\_\_ Obesity
- \_\_\_ Phlebitis
- \_\_\_ Sleep Apnea
- \_\_\_ Other: \_\_\_\_\_
- \_\_\_ Chronic Renal Failure
- \_\_\_ Elevated PSA
- \_\_\_ Epididymitis
- \_\_\_ HIV
- \_\_\_ HPV
- \_\_\_ Interstitial Cystitis
- \_\_\_ Kidney Disease
- \_\_\_ Kidney Infection
- \_\_\_ Kidney Stones
- \_\_\_ Penile Discharge
- \_\_\_ Prostate Cancer
- \_\_\_ Undescended Testicle
- \_\_\_ Urinary Tract Infection
- \_\_\_ Venereal Disease
- \_\_\_ Bladder Cancer
- \_\_\_ Erectile Dysfunction
- \_\_\_ Infertility
- \_\_\_ Pre-mature ejaculation
- \_\_\_ Testicular Cancer
- \_\_\_ Other: \_\_\_\_\_

#### GASTROINTESTINAL:

- \_\_\_ Cholecystitis
- \_\_\_ Cholelithiasis
- \_\_\_ Chronic Liver Disease
- \_\_\_ Colitis
- \_\_\_ Constipation
- \_\_\_ Colon Condition
- \_\_\_ Crohn's Disease
- \_\_\_ Diarrhea
- \_\_\_ Diverticulitis
- \_\_\_ Diverticulosis
- \_\_\_ GERD
- \_\_\_ Hemorrhoids
- \_\_\_ Hiatal Hernia
- \_\_\_ Inflammatory Bowel Disease
- \_\_\_ Liver Disease
- \_\_\_ Pancreatitis
- \_\_\_ Peptic Ulcer
- \_\_\_ Rectal Fissure
- \_\_\_ Stomach Ulcer
- \_\_\_ Other: \_\_\_\_\_

#### GENITOURINARY:

- \_\_\_ Acute Prostatitis
- \_\_\_ AIDS
- \_\_\_ Benign Prostatic Hypertrophy
- \_\_\_ Bladder Infection
- \_\_\_ Chronic Prostatitis
- \_\_\_ Chronic Renal Insufficiency

- \_\_\_ Chronic Fatigue Syndrome
- \_\_\_ Depression
- \_\_\_ Eating Disorder
- \_\_\_ Epilepsy
- \_\_\_ Herniated Disc
- \_\_\_ Mental Illness
- \_\_\_ Migraine
- \_\_\_ Nervous Breakdown
- \_\_\_ Parkinson's Disease
- \_\_\_ Polio
- \_\_\_ Stroke
- \_\_\_ Suicide Attempt
- \_\_\_ Other: \_\_\_\_\_

#### RESPIRATORY:

- \_\_\_ Asthma
- \_\_\_ Bronchitis
- \_\_\_ Chronic Lung Disease
- \_\_\_ COPD
- \_\_\_ Emphysema
- \_\_\_ Pulmonary Embolism
- \_\_\_ Tuberculosis
- \_\_\_ Other: \_\_\_\_\_

#### TUMORS:

- \_\_\_ Brain Tumors
- \_\_\_ Breast Cancer
- \_\_\_ Cervical Cancer
- \_\_\_ Colon Cancer
- \_\_\_ Gastric Cancer
- \_\_\_ Laryngeal Cancer
- \_\_\_ Lung Cancer
- \_\_\_ Lymphoma
- \_\_\_ Melanoma
- \_\_\_ Pancreatic Cancer
- \_\_\_ Rectal Cancer
- \_\_\_ Other: \_\_\_\_\_

#### HEENT:

- \_\_\_ Blindness
- \_\_\_ Cataracts
- \_\_\_ Deafness
- \_\_\_ Ear Infection
- \_\_\_ Glaucoma
- \_\_\_ Hay Fever
- \_\_\_ Mumps
- \_\_\_ Vertigo
- \_\_\_ Other: \_\_\_\_\_

#### MUSCULOSKELETAL:

- \_\_\_ Arthritis
- \_\_\_ Back Pain
- \_\_\_ Carpal Tunnel Syndrome
- \_\_\_ Fibromyalgia
- \_\_\_ Other: \_\_\_\_\_

#### Neurological/Psychological:

- \_\_\_ ADD
- \_\_\_ ADHD
- \_\_\_ Alcoholism
- \_\_\_ Alzheimer's Disease
- \_\_\_ Anxiety Disorder
- \_\_\_ Bi-Polar

**SURGICAL HISTORY**

Please list any surgeries you have had and date of surgery:

---



---



---

**FAMILY HISTORY**

Please mark ( X ) if a parent, sibling, aunt, uncle and/or grandparent has/had any of the following.:

Mark ( X ) if applies	Condition:	Relationship to you:
	Arthritis	
	Bedwetting	
	Bladder Cancer	
	Cancer:	
	Crohn's Disease	
	Depression	
	Diabetes	
	Gout	
	Heart Attack	
	Hypertension	
	Kidney Disease, <i>Please specify:</i>	
	Kidney Stones	
	Leukemia	
	Malignant Melanoma	
	Multiple Sclerosis	
	Laryngeal Cancer	
	Pancreatic Cancer	
	Prostate Cancer	
	Stroke	
	Thyroid Disease	
	Tuberculosis	
	Other:	

**SOCIAL HISTORY**

Please provide the following information:

**Advanced Directives:**

Living Will     Durable Power Of Attorney     Do Not Resuscitate (DNR)     Organ Donor

**Marital Status:**

Single     Married     Separated     Divorced     Widowed     Life Partner     Common Law Spouse

**Occupation – Please CIRCLE the one that applies:**

None    Laborer    Truck Driver    Tradesman    Clerk    Administrative    Executive    Professional    Part-Time    Retired    Other : \_\_\_\_\_

**Alcohol Consumption:**

\_\_\_\_\_ None    \_\_\_\_\_ Yes    Occasional / Social    # of drinks per day \_\_\_\_\_

**Tobacco per day:**

\_\_\_\_\_ None    \_\_\_\_\_ Yes    # \_\_\_\_\_ Packs/day    \_\_\_\_\_ Cigarettes/day    \_\_\_\_\_ Smokeless Tobacco

If you previously stopped smoking when? \_\_\_\_\_

**Recreational Drugs:** \_\_\_\_\_ None    If Yes, please list: \_\_\_\_\_

**Caffeinated beverages:** \_\_\_\_\_ None    \_\_\_\_\_ Low    \_\_\_\_\_ Moderate    \_\_\_\_\_ Excessive

Print Name \_\_\_\_\_

**ALLERGIES-** Please list ALL types (Drug, Seasonal, Pets, Environmental, foods)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_ PHONE# \_\_\_\_\_

PHARMACY ADDRESS: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**CURRENT MEDICATIONS-** Please list ALL medications you are currently taking including over the counter

Medicine: Drug name:	Strength:	Directions/How you take it:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Attach medication list if necessary**

**FEMALE HISTORY:**

Number of pregnancies \_\_\_\_\_ Episiotomy: Y/N  
Deliveries: Vaginal \_\_\_\_\_ Cesarean \_\_\_\_\_ Miscarriages(s): \_\_\_\_\_ Abortions(s) \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Please mark (x) if you have any of the following:

**CONSTITUTIONAL:**  
 Chills  Fatigue  Fever  Night Sweats  Victim of Domestic Violence  Weight Gain  Weight Loss

**EYES:**  
 Blurred Vision  Eye drainage  Eye pain  Glasses/Contacts  Photophobia

**EARS/NOSE/THROAT:**  
 Ear pain  Hearing problems  Tinnitus  Epitaxis  Nasal congestion  Non healing nasal ulcer  
 Rhinorrhea  Bleeding gums  Peridental disease  Dentures  Hoarseness  Sore/Ulcer in mouth  
 Sore throat  Sore tongue  Thrush  Tooth pain

**CARDIOVASCULAR:**  
 Chest pain  Claudication  Dizziness  Orthopnea  Palpitations  Paroxysmal nocturnal dyspnea  
 Pedal edema  Tachycardia  Varicose veins

**RESPIRATORY:**  
 Acute cough  Chronic Cough  Dyspnea  Exposure to TB  Hemoptysis  Pleuritic pain  Wheezing

Print Name \_\_\_\_\_

**GASTROINTESTINAL:**

\_\_\_ Abdominal pain \_\_\_ Acid reflux \_\_\_ Anorexia \_\_\_ Bloating \_\_\_ Dysphagia \_\_\_ Clay colored stool \_\_\_ Constipation  
\_\_\_ Diarrhea \_\_\_ Heartburn \_\_\_ Hematemesis \_\_\_ Hematochezia \_\_\_ Hemorrhoids \_\_\_ Melena \_\_\_ Nausea \_\_\_ Vomiting  
\_\_\_ Odynophagia \_\_\_ Stool caliber change

**GENITOURINARY:**

\_\_\_ Dysmenorrhe \_\_\_ Dysparina \_\_\_ Dysuria \_\_\_ Genital lesions \_\_\_ Hematuria \_\_\_ High risk sexual behavior \_\_\_ HX UTI's  
\_\_\_ HX Bacterial vaginosis \_\_\_ Irregular menstrual cycles \_\_\_ Menorrhagia \_\_\_ Nocturia \_\_\_ Polyuria \_\_\_ Hx Rape  
\_\_\_ Post coital vaginal bleeding \_\_\_ Post menopausal bleeding \_\_\_ Sexual abuse \_\_\_ Urinary Incontinence \_\_\_ Vaginal discharge  
\_\_\_ Vaginal itching \_\_\_ Unprotected intercourse \_\_\_ Impotence \_\_\_ Urine stream change

**MUSCULOSKELETAL:**

\_\_\_ Arthralgias \_\_\_ Back pain \_\_\_ Joint stiffness \_\_\_ Limb pain \_\_\_ Myalgias

**INTEGUMENTARY/BREAST:**

\_\_\_ Acne \_\_\_ Atypical mole \_\_\_ Dry skin \_\_\_ Fungal nail infection \_\_\_ Jaundice \_\_\_ Pruritis \_\_\_ rash(es) \_\_\_ Wart(s) \_\_\_ Breast mass  
\_\_\_ Breast skin changes \_\_\_ Breast tenderness \_\_\_ Nipple discharge  
Yes or No Self Breast Exams

**NEUROLOGICAL:**

\_\_\_ Ataxia \_\_\_ Dizziness \_\_\_ Fainting \_\_\_ Headaches \_\_\_ Memory loss \_\_\_ Paresthesia \_\_\_ Seizures \_\_\_ Tremor \_\_\_ Vertigo  
\_\_\_ Weakness

**HEMATOLOGIC/LYMPHATIC:**

\_\_\_ Easy bruising \_\_\_ Excessive bleeding \_\_\_ HX. Of blood transfusion \_\_\_ Lymphadenopathy

**ENDOCRINE:**

\_\_\_ enlarged hands/feet \_\_\_ Hair loss \_\_\_ Heat/cold intolerance \_\_\_ Hirsutism \_\_\_ Hot flashes  
\_\_\_ Increased skin pigmentation \_\_\_ Infertility \_\_\_ Polydipsia \_\_\_ Striae \_\_\_ Excessive sweating

**ALLERGIC/IMMUNOLOGIC:**

\_\_\_ Seasonal allergies/"hayfever" \_\_\_ Perennial allergies \_\_\_ Frequent URI's \_\_\_ HIV risk factors \_\_\_ Urticaria

**PSYCHIATRIC:**

\_\_\_ Anxiety \_\_\_ Crying spells \_\_\_ Depression \_\_\_ Feeling Stressed \_\_\_ Loss of interest in pleasure  
\_\_\_ Mood swings \_\_\_ Personality changes \_\_\_ PMS \_\_\_ Poor concentration \_\_\_ Recreational drug use  
\_\_\_ Sadness \_\_\_ Sleep disturbances \_\_\_ Suicidal thoughts

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_