

**UPPER CUMBERLAND UROLOGY ASSOCIATES, P.C.  
PATIENT HISTORY FORM - NEW**

TODAY'S DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ CHART #: \_\_\_\_\_

AGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ REFERRING DOCTOR: \_\_\_\_\_

REASON FOR VISIT TODAY: \_\_\_\_\_

WHEN DID THIS PROBLEM FIRST BEGIN? \_\_\_\_\_

**IF YOU HAVE PAIN ASSOCIATED WITH IT, PLEASE ANSWER THE FOLLOWING QUESTIONS:**

Is the pain sharp, dull, burning, ache? \_\_\_\_\_ How severe? \_\_\_\_\_ (1=mild, 5=moderate, 10=worst imaginable)

Where is it located? \_\_\_\_\_ Does it travel anywhere? \_\_\_\_\_

Intermittent or constant? \_\_\_\_\_ How long does it last? \_\_\_\_\_ How often does it occur? \_\_\_\_\_

Does any position (e.g. sitting, standing, lying) or medication make it better or worse? \_\_\_\_\_

Any other associated symptoms? (e.g. burning on urination, fever, vomiting, etc.) \_\_\_\_\_

**IF YES, PLEASE ANSWER THE FOLLOWING QUESTIONS:**

Have you received treatment (medicines or surgery) for this condition? **YES** **NO** \_\_\_\_\_

Have you had a cystoscopy? **YES** **NO** Date and results: \_\_\_\_\_

Have you had X-rays (IVP, ultrasound, CAT scan, MRI)? **YES** **NO** \_\_\_\_\_

**WHAT ARE YOUR CURRENT MEDICAL PROBLEMS?**

High blood pressure	<b>Y</b>	<b>N</b>	Cancer - type: _____
High cholesterol	<b>Y</b>	<b>N</b>	_____
COPD	<b>Y</b>	<b>N</b>	_____
Stroke	<b>Y</b>	<b>N</b>	_____

**HAVE YOU EVER HAD SURGERY? IF YES, GIVE THE YEAR AND ANSWER RT. OR LT.**

<i>Surgery</i>	<i>Year</i>	<i>Surgery</i>	<i>Year</i>	<i>Surgery</i>	<i>Year</i>
Appendectomy	_____	Cataract <b>Rt.</b> <b>Lt.</b>	_____	Hip surgery <b>Rt.</b> <b>Lt.</b>	_____
Back surgery	_____	Gallbladder	_____	Hysterectomy	_____
Bladder surgery	_____	Heart surgery	_____	Knee surgery <b>Rt.</b> <b>Lt.</b>	_____
Breast surgery	_____	Hernia repair <b>Rt.</b> <b>Lt.</b>	_____	Sinus surgery	_____
				Tonsillectomy	_____

**OTHER SURGERIES?** \_\_\_\_\_

**FEMALE HISTORY:** Are you having periods? **Yes** **No** If so, when was your last period? \_\_\_\_\_

Are your periods regular? **Yes** **No** Do you have a vaginal discharge? **Yes** **No**

Are you menopausal? **Yes** **No** Are you pregnant? **Yes** **No**

# of times pregnant: \_\_\_\_\_ # of deliveries: \_\_\_\_\_ Delivery method: vaginal \_\_\_\_\_ c-section \_\_\_\_\_



**PAST MEDICAL HISTORY:** (Please Circle **Y** or **N**)

Arthritis	Y	N	GERD/Reflux	Y	N
BPH	Y	N	High Cholesterol	Y	N
CHF	Y	N	Hypertension	Y	N
COPD	Y	N	Hypothyroidism	Y	N
Bronchitis	Y	N	Kidney Insufficiency/ Failure	Y	N
Asthma	Y	N	Kidney Stones	Y	N
Cancer	Y	N	Liver Disease	Y	N
Coronary Artery Disease	Y	N	Nausea/Vomiting or Stomach Pain	Y	N
DVT w/Pulm. Emb.	Y	N	Parkinson' Disease	Y	N
Depression	Y	N	Psychiatric Disorder	Y	N
Diabetes	Y	N	Seizure Disorder or Other Neurological Problem	Y	N
Drug/Alcohol Abuse	Y	N	Stroke	Y	N
Fibromyalgia	Y	N			

**Other Allergies/Adverse Reactions:**

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