Urology Clinics of North Texas
HEALTH HISTORY FORM **Acct#________________**

Patient Name: ____Date: ___________________

Referring doctor ____

Reason for your visit today____

Drug Allergies: ____

Medications: Please list any prescription medications or over-the-counter medications you take routinely: Medication_________________________________Dosage__________________
Medication_________________________________Dosage__________________
Medication_________________________________Dosage__________________
Medication_________________________________Dosage__________________

Past Medical Illnesses: Please check any of the following conditions which you have had or presently have: ___ Hypertension ___ Heart disease Other: _________________________________
___ Diabetes ___ Hepatitis ____
___ Meningitis ___ Thyroid ____

Past Surgical History: Please list any surgical procedures you have had performed and the date of the procedure:
Date: _______________Procedure: _______________________________________
Date: _______________Procedure: _______________________________________
Date: _______________Procedure: _______________________________________
Date: _______________Procedure: _______________________________________
Date: _______________Procedure: _______________________________________

Habits: Do you smoke cigarettes? No___ Yes ___ How many packs per day? ___________
Do you drink alcohol? No ____ Yes ____ How often? _____________________________

Social History:
Marital status: Single___ Divorced ___ Widow/Widower___Married ___ (# yrs married______)
Do you have children? No____ Yes____ How many? _____________________________________
What is your occupation? ____
Females only: Last menstrual period ____/____/____ Birth control method_____________________
#pregnancies____ # births____ # miscarriages ____ # abortions_____

Family History: Please place a check in the appropriate box. If the answer is yes, list the family member affected.**Disease**	**Yes**	**No**	**Family member(s) affected**
Hypertension			
Heart disease			
Cancer: list type and location			
Cysts or tumors of kidneys			
Sickle cell disease or trait			
Any family member on dialysis			

Indicate whether or not you suffer from the following symptoms on a frequent or chronic basis by checking the appropriate box. If your answer is YES, please describe the symptoms in further detail.

Symptoms	Yes	No	Describe
1. Unexplained weight loss			
2. Fever, chills, night sweats			
3. Nausea or vomiting			
4. Blurred vision or double vision			
5. Runny nose			
6. Difficulty swallowing			
7. Chest pain			
8. Shortness of breath			
9. Diarrhea			
10. Abdominal pain			
11. Muscular weakness, numbness or joint pain			
12. Itching or skin rashes			
13. Headaches			
14. Dizziness or fainting			
15. Anxiety or depression			
16. Tiredness			
17. Hyperactivity			
18. Extreme thirst			
19. Easy bruising or bleeding			

What is your height? _______ft ______ in

What is your usual weight? __________ lbs