Patient Name: ____

Health History

Problems

Reason for today's visit: ______________________________ Onset (date): ______________

Allergies/Adverse Reactions

Drug/Allergen: ____________________ Reaction: ______________________ Date: __________

Drug/Allergen: ____________________ Reaction: ______________________ Date: __________

Drug/Allergen: ____________________ Reaction: ______________________ Date: __________

Family History

Relation: __________________ Problem: __________________ Onset Age: _____ Age of Death: _____

Relation: __________________ Problem: __________________ Onset Age: _____ Age of Death: _____

Surgical History

Procedure: ____________________________ Surgery Date: ______________________

Procedure: ____________________________ Surgery Date: ______________________

Procedure: ____________________________ Surgery Date: ______________________

Vaccines

Did you get the flu shot this year? If so, when? ____________________________

Did you get the pneumonia vaccination this year? If so, when? ____________________________

Social History *(Please circle)*

Smoking Status: Never smoker Former smoker Current Smoker (every day) Current Smoker (some days)

Smoking – How much? None ¼ PPD ½ PPD 1 PPD 1½ PPD 2 PPD 3+ PPD

Chewing Tobacco: None 1/day 2-3/day 5+day

Tobacco - Years of Use: ________ Has smoked since age: ________

Alcohol Intake: None Occasional Moderate Heavy Years of Use: __________________

Do you use illicit drugs? None Marijuana Cocaine Heroin Ecstasy Inhalants Other: ________

Do you have children? Yes No Do you have an Advanced Directive? Yes No

Hobbies/Activities: ______________________________ Caffeine intake: ____________________

Occupation: ________________________ Have you had a colonoscopy? If yes, date: ________________

Medications you currently take and the dosage. Please include all medications prescribed by a physician and over the counter medications such as Tylenol, Motrin and all herbal medications.

Medication Name	Dosage

NEW JERSEY UROLOGY
Excellence In Care

Patient Name: ____________________

Past Medical History – Please check all that apply

ADD/ADHD		Dementia/Alzheimer's Disease		Hyper/Hypothyroidism (over/underactive thyroid)		Prostate Cancer	
Abnormal heart rhythm/Atrial fibrillation		Depression		Infertility		Prostatitis	
Abscess		Diabetes		Interstitial Cystitis		Pulmonary Embolism	
Anemia		Dialysis		Irritable Bowel Syndrome		Pulmonary Hypertension	
Angina (chest pain)		Diverticulosis/Diverticulitis		Kidney Cancer		Renal Disease	
Anxiety		Eating Disorder		Kidney Stone		Rheumatoid Arthritis	
Arthritis		Elevated PSA		Lung Cancer		Schizophrenia	
Asthma		Endometriosis		Lupus		Sciatica	
BPH/Enlarged Prostate		Epilepsy (seizures)		MRSA Infection		Seasonal Allergies	
Barrett's Esophagus		Erectile Dysfunction		Major Depressive Disorder		Sepsis	
Bipolar Disorder		Fibroids		Migraine Headaches		Sexually Transmitted Disease (explain)	
Bladder Cancer		Fibromyalgia		Multiple Sclerosis		Skin Cancer	
Bladder Stones		GERD/Acid Reflux		Obesity		Skin Conditions	
Brain Cancer		GI Bleed		Osteoporosis		Sleep Apnea	
Breast Cancer		Gallstones		Ovarian Cancer		Stomach Cancer	
COPD (Emphysema/chronic bronchitis)		Gastritis/Ulcers		Ovarian Cyst		Stroke/TIA	
Cataract		Glaucoma		PTSD		Syncope (fainting)	
Cervical Cancer or Cervical Dysplasia		Gout		Pancreatitis		Testicular Cancer	
Chronic Pelvic Pain Syndrome		HIV Infection/AIDS		Parkinson's Disease		Tuberculosis/TB Exposure	
Chronic Back Pain		Heart Attack		Pelvic Organ Prolapse		Ulcerative Colitis	
Chronic Kidney Disease		Hemorrhoids		Pelvic Prolapse		Urinary Tract Infection (UTI)	
Colorectal Cancer		Hepatitis		Peripheral Vascular Disease		Uterine Cancer	
Congestive Heart Failure		Herniated Disc		Peyronie's Disease		Vaginal Cancer	
Coronary Artery Disease		High Cholesterol		Peripheral Vascular Disease		Varicose Veins	
Chron's Disease		Hydrocele		Pneumonia		Vertigo	
DVT (Blood Clot)		Hypertension		Polycystic Ovary Syndrome		Vulvodynia	

Patient History – Can you think of anything else about you that your physician may need to know?

____

____

____

NEW JERSEY UROLOGY
Excellence In Care

Patient Name: ______________________________

Review of Systems - *Please circle any symptoms that you are currently experiencing:*

Constitutional

Fever	Yes	No
Fatigue	Yes	No
Chills	Yes	No
Weight gain (____lbs.)	Yes	No
Weight loss (____lbs.)	Yes	No

Eyes

Dry eyes	Yes	No
Vision change	Yes	No
Eye irritation	Yes	No

Ears, Nose and Throat

Hearing loss	Yes	No
Nose bleeds	Yes	No
Sinus problems	Yes	No
Sore throat	Yes	No
Dry mouth	Yes	No

Cardiovascular

Chest pain	Yes	No
Palpitations	Yes	No
Leg edema	Yes	No

Respiratory

Cough	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No

Gastrointestinal

Abdominal pain	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Loss of appetite	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Bloody/black stool	Yes	No
Heartburn	Yes	No
Bowel leakage	Yes	No

Urinary

Difficulty/straining to urinate	Yes	No
Incomplete bladder emptying	Yes	No
Sudden need to urinate	Yes	No
Urine leakage	Yes	No
Painful urination	Yes	No
Slow/weak urinary system	Yes	No
Flank pain (right or left side)	Yes	No
Pelvic pain	Yes	No
Urinary frequency	Yes	No
Blood in urine	Yes	No
Waking from sleep to urinate	Yes	No

Musculoskeletal

Joint pain	Yes	No
Muscle pain	Yes	No
Back pain	Yes	No

Skin

Rashes	Yes	No
Itching/dryness	Yes	No
Abnormal moles	Yes	No

MALE ONLY ♂:

Testicular pain	Yes	No
Erectile problems	Yes	No
Painful intercourse	Yes	No
Low sex drive	Yes	No
Penile curvature	Yes	No

FEMALE ONLY ♀:

Irregular periods	Yes	No
Vaginal discharge	Yes	No
Painful intercourse	Yes	No
Low sex drive	Yes	No
Breast pain/lump	Yes	No

Date of last mammogram ________________

Date of last pap smear ___________________

Neurologic

Dizziness	Yes	No
Numbness	Yes	No
Headaches	Yes	No
Tremors	Yes	No

Psychiatric

Stress	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Memory Loss	Yes	No

Endocrine

Excessive thirst	Yes	No
Heat/cold intolerance	Yes	No
Hot flashes	Yes	No

Hematologic/Lymphatic:

Swollen glands	Yes	No
Bruising easily	Yes	No
Excessive bleeding	Yes	No