Today's Date_____ # Springfield Urology Patient Information (Review of Symptoms)

Name_____**Age**_____ **DOB**_____

Chief Complaint: *Please list the reasons for seeing the doctor, be as specific as you can*_____

_____

Medications*: List all medications you are taking and the dosages*_____

_____

_____

Allergies: Do you have any allergies? YES□ NO□
Please list any allergies to medications, foods, X-Ray Dye_____

Surgery: *Please list any surgical/ anesthetic procedures and approximate date*

_____ _____
_____ _____
_____ _____

Family History: *Does anyone in your family (parents, siblings, and children) have the following? If yes, list family member*

Diabetes: YES□ NO□ _____
Heart Disease: YES□ NO□ _____
Kidney Disease/ Stones: YES□ NO□ _____
Prostate Cancer: YES□ NO□ _____
Cancer: YES□ NO□ _____

Social History:

Occupation/ Former occupation:_____
Current Smoker? YES□ NO□ Prior Smoker? YES□ NO□
Packs per day?_____ How many yrs?_____ Year Quit?_____
Do you use alcohol?_____ How much?_____ Other drugs?_____

Gynecologic: # of pregnancies_____ # of children?_____ Last Menstrual Period?_____

Do you now or have you had any problems related to the following systems? Circle Yes or No
Please explain any Yes answers in the space provided.

Constitutional			**Endocrine**		
Fatigue	Y	N	Cold intolerance	Y	N
Fever	Y	N	Heat intolerance	Y	N
Night Sweats	Y	N	Excessive Thirst	Y	N
Eye, Ear, Nose, Throat			Excessive Eating	Y	N
Ear Drainage	Y	N	Diabetes	Y	N
Hearing Loss	Y	N	**Neurological**		
Nasal Drainage	Y	N	Gait Disturbance	Y	N
Eye Discharge	Y	N	Stroke	Y	N
Vision Loss	Y	N	Seizures	Y	N
Respiratory			**Muscular/ Skeletal**		
Cough	Y	N	Bone/ Joint symptoms	Y	N
Difficulty Breathing	Y	N	Bone/ Joint Weakness	Y	N
Wheezing	Y	N	Arthritis	Y	N
Cardiovascular			Gout	Y	N
Chest Pain	Y	N	**Dermatology**		
Irregular Heartbeat/ Palpitations	Y	N	Rash	Y	N
High Blood Pressure	Y	N	Eczema	Y	N
Murmur	Y	N	Psoriasis	Y	N
Valve problem	Y	N	Shingles	Y	N
Gastrointestinal			**Psychiatric**		
Abdominal Pain	Y	N	Psychiatric Symptoms	Y	N
Constipation	Y	N	Anxiety	Y	N
Diarrhea	Y	N	Depression	Y	N
Vomiting	Y	N	**Allergic / Immune**		
Peripheral Vascular			Environmental Allergies	Y	N
Leg pain while walking	Y	N	Food Allergies	Y	N
Varicose veins	Y	N	**Blood/ Oncology**	Y	N
Phlebitis	Y	N	Bleeds Easy	Y	N
Deep vein thrombosis	Y	N	Easy Bruising	Y	N
			Cancer	Y	N

Dr. _____Reviewed the following information on_____.
Signature Date