BAPTIST Urology Group

Medical and social history form

Date: _____ Patient name: _____

Date of birth: _____ Age: _____

Allergies: ☐ No ☐ Yes, list allergies: _____

_____

Exercise: _____

Daily activities: _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Most recent occupation: _____

Number of children: _____ Number of pregnancies: _____

Smoking: ☐ No ☐ Yes, how many/day? _____ How long? _____ yrs Date quit: _____

Alcohol: How much/day? _____ Caffeine (coffee, tea, cola) How much/day? _____

Illicit Drug Use: ☐ No ☐ Yes, currently using: _____

Prior Problem? ☐ No ☐ Yes, explain: _____

Please list all past surgeries with dates	Please list all personal illnesses or injuries and dates

Family history: *(Check only those boxes that are positive)*

☐ Diabetes ☐ Heart disease ☐ High blood pressure ☐ Stroke ☐ TB

☐ Cancer ☐ Kidney disease ☐ Anemia ☐ Arthritis ☐ Mental illness

Please explain boxes that are checked: _____

Mother: ☐ Living ☐ Deceased, age: _____ Cause of death: _____

Father: ☐ Living ☐ Deceased, age: _____ Cause of death: _____

Date:_____ Patient name: _____DOB:_____

Review of systems: *(Please check each item "yes" or "no" as they relate to your health)*

CONSTITUTIONAL	Yes	No
Weight Loss	☐	☐
Fatigue	☐	☐
Fever	☐	☐

EYES		
Glasses/contacts	☐	☐
Pain	☐	☐
Double vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐

EAR, NOSE, THROAT		
Difficulty hearing	☐	☐
Ringing in ears	☐	☐
Vertigo	☐	☐
Sinus trouble	☐	☐
Nasal stuffiness	☐	☐
Frequent sore throat	☐	☐
Hoarseness	☐	☐

CARDIOVASCULAR		
Murmur	☐	☐
Chest pain	☐	☐
Palpitations	☐	☐
Dizziness	☐	☐
Fainting spells	☐	☐
Short of breath	☐	☐
Difficulty lying flat	☐	☐
Swelling ankles/other	☐	☐

RESPIRATORY		
Cough	☐	☐
Coughing blood	☐	☐
Wheezing	☐	☐
Chills	☐	☐

GASTROINTESTINAL	Yes	No
Heartburn	☐	☐
Nausea/vomiting	☐	☐
Constipation	☐	☐
Change in BM's	☐	☐
Diarrhea	☐	☐
Difficulty swallowing	☐	☐
Jaundice	☐	☐
Abdomen pain	☐	☐
Black BM	☐	☐

GENITOURINARY		
Pain urinating	☐	☐
Burning	☐	☐
Frequency	☐	☐
Nighttime	☐	☐
Blood in urine	☐	☐
Difficulty urinating	☐	☐
History of kidney stones	☐	☐
History of sexually transmitted disease	☐	☐
Abnormal discharge	☐	☐

FEMALE ONLY		
Age onset of periods _____		
Age onset of menopause_____		
Are your periods regular?	☐	☐

HEMATOLOGIC/LYMPH		
Easily bruise	☐	☐
Gums bleeding easily	☐	☐
Enlarged glands	☐	☐
Prolonged bleeding	☐	☐

MUSCULOSKELETAL	Yes	No
Joint pain/swelling	☐	☐
Stiffness	☐	☐
Muscle pain	☐	☐
Back pain	☐	☐

SKIN		
Rash/sores	☐	☐
Lesions	☐	☐
Itching/burning	☐	☐

NEUROLOGICAL		
Seizures	☐	☐
Weakness/paralysis	☐	☐
Numbness	☐	☐
Tremors	☐	☐
Memory loss	☐	☐

ENDOCRINE		
Loss of hair	☐	☐
Eat/cold intolerance	☐	☐
Change in nails	☐	☐

ALLERGIC/IMMUNOLOGIC		
Hay fever/Asthma	☐	☐
Hives/Eczema	☐	☐

PSYCHIATRIC		
Anxiety/depression	☐	☐
Mood swings	☐	☐
Difficulty sleeping	☐	☐

Please list all medications including dosage and frequency: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of staff member review of completion Signature of physician review