CULLMAN UROLOGY PC

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Adult Patient History

Date: _____/_____/_____

NAME (First, M, Last): _____ **DOB:** _____/_____/_____

Race: White Black/African American Hispanic Other

Name of Pharmacy: _____

Referring Physician: _____

Primary Care Physician: _____

COMPLAINT: _____

_____

PAINFUL URINATION	BLOOD IN URINE	LEAKAGE
HESITATION BEFORE STARTING	WEAK STREAM	FEVER
FREQUENT URINATION	STRAIN TO URINATE	PAIN OVER BLADDER
PAIN OVER KIDNEYS	TESTICULAR PROBLEMS	

ALLERGIES:

_____

_____

CONSTITUTIONAL:	CHILLS	FEVER	WEIGHT LOSS
EYES:	BLURRY VISION	DOUBLE VISION	CATARACTS
EARS/NOSE/THROAT:	HEARING LOSS	NASAL STUFFINESS	SORE THROAT
CARDIAC:	SWOLLEN ANKLES	HIGH BLOOD PRESSURE	IRREGULAR HEART BEAT
RESPIRATORY:	SHORT OF BREATH	WHEEZING	CHRONIC COUGH
GI:	ABD PAIN	NAUSEA/VOMITING	CHANGE IN BOWELS
SKIN:	RASH	PERSISENT ITCHING	HISTORY OF SKIN CANCER
NEURO:	TINGLING	DIZZINESS	NUMBNESS

PAST MEDICAL HISTORY: _____

_____

ASTHMA/EMPHYSEMA/COPD	DIABETES	KIDNEY DISEASE	ARTHRITIS
THYROID CONDITION	SEIZURES	STROKE	BLEEDING PROBLEM
HIGH BLOOD PRESSURE	KIDNEY STONES	ULCER DISEASE	BACK INJURY
HEART ATTACK/HEART CONDITION			

SURGICAL HISTORY: _____

_____

SOCIAL HISTORY

PLEASE CIRCLE: MARRIED SINGLE DIVORCED WIDOWED

OCCUPATION: _____

DO YOU OR DID YOU SMOKE? NO NOW IN THE PAST

NUMBER OF PACKS PER DAY: _____ FOR HOW LONG? _____ QUIT WHAT YEAR? _____

DO YOU DRINK ALCOHOL? YES NOT ANYMORE NEVER DRANK

HOW MANY CAFFEINATED DRINKS DO YOU HAVE EVERY DAY? 0 1 2 3 4+

WOMEN ONLY: DATE OF YOUR MENSTRUAL PERIOD _____

FAMILY HISTORY

WHO IN YOUR FAMILY HAS HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

DIABETES _____

PROSTATE CANCER _____

OTHER CANCER _____

HIGH BLOOD PRESSURE _____

KIDNEY DISEASE _____

KIDNEY STONES _____

OTHER DISEASE (LIST) _____

MEDICATION LIST:

1._____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

13. _____

14. _____

15. _____

X_____ _____/_____/_____

Patient's Signature **Date**