



The Urology Division of Integrated Medical Services (IMS)



HISTORY AND PHYSICAL FORM (PATIENT)

Date: _____ Reason For Visit: _____

Patient Name: _____ Date of Birth: _____ Age: _____ Account: _____

Referred By: _____ Marital Status: Single Height: _____ Weight: _____

Past Medical & Social History (Please fill out completely)

Allergic to (Include Medications):

Surgeries:

Medical Illness:

Glaucoma Tendinitis

Medications (list dose and frequency):

Name	Frequency	Name	Frequency
<input type="checkbox"/> Coumadin	_____	<input type="checkbox"/> Aspirin	_____
<input type="checkbox"/> Heparin	_____	<input type="checkbox"/> Ibuprofen	_____
<input type="checkbox"/> Plavix	_____	<input type="checkbox"/> Lipitor	_____

Other (Please List):

Name	Frequency	Name	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any medical condition that requires antibiotics prior to surgery? YES NO

(Example: Heart Murmur, Prosthetic Hips and Knees) If YES please list:

Tobacco: Now Never In the Past, Amt Per Day _____ Age Started _____ Year Quit _____

Alcohol: Never Rare Occasional Moderate Heavy, Amt/ Type per day _____

Family History & Review of System

Acct #:

List of all major illnesses in your immediate family
(Examples: heart disease, prostate cancer, kidney stones, kidney disease):

Father : _____
 Mother : _____
 Brother : _____
 Sister : _____

Prostate Cancer
 Kidney Stones

Have you experienced any of the following problems recently? **Check YES or NO**

Constitutional Symptoms

Fever Y N
 Chills Y N
 Headaches Y N

Sight/Sound

Blurred Vision Y N
 Glaucoma Y N
 Loss of Hearing/Ringing Y N

Ear/Nose/Throat/Mouth

Ear Infection Y N
 Sore Throat Y N
 Difficulty Swallowing Y N

Integumentary

Skin Rash Y N
 Boils Y N
 Persistent itch Y N

Pulmonary

Wheezing Y N
 Frequent Cough Y N
 Shortness of Breath Y N

Circulatory

Chest Pain Y N
 High Blood Pressure Y N
 Varicose Vein Y N

Gastrointestinal

Hepatitis Y N
 Ulcer/Reflux Y N
 Constipation Y N

Genitourinary

Kidney Failure Y N
 Kidney Stone Y N
 Urinary Tract Infection Y N

Neurological

Dizziness Y N
 Migraine Y N
 Multiple Sclerosis Y N

Musculoskeletal

Back pain/ Surgery Y N
 Muscle Disorder Y N
 Joint Disorder Y N

Endocrine

Diabetes Y N
 Thyroid Disease Y N
 Parathyroid Y N

Hematologic/Lymphatic

Lymph Node Swelling Y N
 Bleeding Disorder Y N
 Immune disorder Y N

Other:

OB/GYN History (Female Patients Only)

Menses: YES NO Hysterectomy: YES NO Number of :Pregnancies _____ Live Births ____

Contraception: None Tubal Ligation Other: _____ Take Estrogens: YES NO

Any Other Information that you like to share:

Patient Name:

Patient Signature: _____