

**Arizona Urology
History & Physical Form**

DATE: _____

Patient Name: _____ Date Of Birth: _____ Age: _____

Height: _____ Weight: _____ Referred by: _____

Past Medical & Social History: (PLEASE FILL OUT COMPLETELY)

Allergic to (Include Meds): _____

Medical Illness: _____

Surgeries: _____

Medications (list dose and frequency): _____

Do you have any medical condition that requires antibiotics prior to surgery? YES or NO
(Examples: heart murmur, prosthetic hips and knees) If YES, please list _____

Tobacco: Y or N If Yes, how much? _____

Marital Status: Married/Single/Divorced

If you quit, how long did you smoke? _____

Children: Y or N If yes, how many? _____

When did you quit? _____

Occupation: _____

Alcohol: Y or N If yes, how much? _____

Family History & Review of System:

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

Have you experienced any of the following problems recently? *Circle 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 disease	Y	N

HEMATOLOGIC/LYMPHATIC

Lymph node swelling	Y	N
Bleeding disorder	Y	N
Immune disorder (ie: HIV)	Y	N

Other: _____

OB/GYN History (If Applicable):

Menses: Y or N Hysterectomy: Y or N Childbirth: Y or N (if yes, how many? _____)
Contraception: None Birth control pills Tubal ligation Other: _____ Take Estrogens: Y or N