RAO V.SUNKAVALLY M.D.,F.A.C.S. **PATIENT HISTORY FORM** *UROLOGY (NewPt H&P Revised 5/2016)*

LAST NAME_____ **FIRST NAME**_____ **TODAY'S DATE**_____

DATE OF BIRTH_____ **REFERRING DOCTOR**_____ **LAST EXAM DATE** _____

CHIEF COMPLAINT What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

History of Present Illness

♦**Note: Please answer the following questions**

1.Location of the problem: ☐ **Abdomen** ☐ **Back** ☐ **Leg** ☐ **Other**_____ ☐ **Front** ☐ **Back**

2.Quality: Is the problem Constant or Variable?

☐**Dull, then Sharp** ☐**Very Sharp then leaves** ☐**Always there** ☐**Other**_____

3.Severity: On a Scale of 1-10, with 10 being the most severe, Circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

4.Duration: When did you first notice the problem?

☐**Two days ago** ☐ **2 weeks ago** ☐**1 month ago** ☐**Other**_____

5.Timing: How long does the problem last?

☐**30mins** ☐**1 hour** ☐**It is always there** ☐**Other**_____

6.Context: Does the problem interfere with your normal functions?

☐**Yes** ☐**No If Yes, please explain**_____

7.Modifying Factors: Does anything help or make the problem worse? like,

☐ **Moving around** ☐**Standing up** ☐**Lying on the side** ☐**Other**_____

8.Associated Signs & Symptoms: Is there anything else occurring at the same time? ☐ **Yes** ☐ **No. If Yes please explain below:**

☐**Nausea** ☐**Rash** ☐**Headaches** ☐**Other**_____

Past, Family & Social History

♦**Medications. Please list all medications you are currently taking.**

DRUG NAME	*DOSE*	*FREQUENCY*	*START DATE*

♦**List any personal past Illnesses and or Surgeries and when they occurred.**

PAST DISEASES OR SURGERIES	*DATE*	*PAST DISEASES OR SURGERIES*	*DATE*
☐*BP* ☐*Diabetes* ☐*Heart Disease* ☐ *Stroke*			

♦**ALLERGIES: Do you have any allergies to medicines or food ?** ☐**No** ☐**Yes If yes, please list below:**

_____

♦**List all serious Illnesses in your Immediate family.**

	YES	*NO*	*RELATION*		*YES*	*NO*	*RELATION*		*YES*	*NO*	*RELATION*
Heart Disease	☐	☐	_____	**Diabetes**	☐	☐	_____	**Cancer**	☐	☐	_____
High Blood Pressure	☐	☐	_____	**Stroke**	☐	☐	_____	**Other**	☐	☐	_____

♦**Do you Drink Alcohol?** ☐**No** ☐**Yes. If yes, what do you drink?**_____ **How much?**_____

♦**Do you Smoke Cigarettes?** ☐**No** ☐**Yes. If yes, how much?**_____ **How long were you smoking?**_____

♦**List all foreign countries you visited in the last 6 months?** _____

*PHYSICIAN USE ONLY:(Comment/Notes)*_____

_____

_____

♦***Do you now have or have you had any of the following problems? Please explain any "Yes" answer***

♦***CONSTITUTIONAL SYMPTOMS:***
1.Fever☐N ☐Y 2.Chills☐N ☐Y 3.Headaches☐N ☐Y 4.Weight loss☐N ☐Y 5.Change in appetite☐N ☐Y
6.Night Sweats☐N ☐Y 6.Other _____

♦***EYES:***
1.Blurred Vision☐N ☐Y 2.Double Vision☐N ☐Y 3.Pain☐N ☐Y 4.Glaucoma☐N ☐Y 5.Other _____
_____

♦***EARS/NOSE/MOUTH/THROAT:***
1.Hearing loss ☐N ☐Y 2.Hay fever☐N ☐Y 3.Loss of Smell☐N ☐Y 4.Sinus Problem☐N ☐Y 5.Other_____
_____

♦***CARDIOVASCULAR:***
1.Chest Pains☐N ☐Y 2.Irregular Heart Beat☐N ☐Y 3.Palpitations☐N ☐Y 4.Varicose Veins☐N ☐Y 4.Swollen feet ☐N ☐Y
5.Other _____

♦***RESPIRATORY:***
1.Wheezing☐N ☐Y 2.Frequent Cough☐N ☐Y 3.Shortness of Breath ☐N ☐Y 4.Exposure to Tuberculosis ☐N ☐Y
5.Other _____

♦***GASTROINTESTINAL:***
1.Abdominal Pain☐N ☐Y 2.Nausea/Vomiting☐N ☐Y 3.Constipation☐N ☐Y 4.Blood in stools☐N ☐Y 5. Other_____
_____

♦***GENITOURINARY:***
1.Urine Retention ☐N ☐Y 2.Painful Urination ☐N ☐Y 3.Blood in Urine ☐N ☐Y 4.Exposure to any STD(Sexually transmitted infections)☐N ☐Y 5.Other_____

♦***MUSCULSKELETAL:***
1.Joint Pain☐N ☐Y 2.Neck Pain☐N ☐Y 3.Back Pain☐N ☐Y 4.Back Injury☐N ☐Y 5.Other_____
_____

♦***INTEGUMENTARY:***
1.Skin Rash☐N ☐Y 2.Persistant Itch☐N ☐Y 3.Boils☐N ☐Y 4.Keloids☐N ☐Y 5.Other_____
_____

♦***NEUROLOGICAL:***
1.Tremors☐N ☐Y 2.Dizziness☐N ☐Y 3.Numbness/Tingling☐N ☐Y 4. Memory Loss☐N ☐Y 5.Other_____
_____

♦***PSYCHIATRIC:***
1.Depression☐N ☐Y 2.Anxiety☐N ☐Y 3.Suicidal Tendencies☐N ☐Y 4.Delusions☐N ☐Y 5.Other_____
_____

♦***ENDOCRINE:***
1.Excessive Thirst ☐N ☐Y 2.Too Hot/Cold ☐N ☐Y 3.Tired/sluggish ☐N ☐Y 4.Other_____
_____

♦***HEMATOLOGIC/LYMPHATIC:***
1.Swollen Glands ☐N ☐Y 2.Blood clotting Problem ☐N ☐Y 3.Anemia☐N ☐Y 4.Exposure to HIV(human immunodeficiency virus)☐N ☐Y 5.Recent blood transfusions ☐N ☐Y 6.Other_____

♦***ALLERGIC/IMMUNOLOGIC:***
1.Hay Fever ☐N ☐Y 2.Hives ☐N ☐Y 3.Sneezing ☐N ☐Y 4.Itching ☐N ☐Y 5.Other_____

*PHYSICIAN USE ONLY: (Comments/Notes)*_____
_____
_____
_____
_____
_____

NEW PATIENT REVIEW OF SYSTEMS (0-1 = 1 or 2; 2-9 = 3; 10+ = 4 or 5) **PATIENT SIGNATURE OR INITIALS**_____

EST PATIENT REVIEW OF SYSTEMS (0 = 1 or 2; PERT=3; 2-9 = 4; 10+ = 5) **DATE:**_____