UCI UROLOGY CENTER OF IOWA

ESTABLISHED PATIENT HISTORY OF PRESENT ILLNESS

Patient Name:_____ DOB:_____

Primary Care Physician:_____

REASON FOR VISIT: _____

ALLERGIES
(Include medications, foods, and/or x-ray dyes, etc.) or ☐ NONE KNOWN

Name of allergen	Type of reaction
1	
2	
3	

CURRENT MEDICATIONS
(Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary.):
Please list any changes in medication since last visit:

_____

_____

☐ **No Changes in medication since last visit**

PHARMACY **(List pharmacy most frequently used for prescriptions)**

Name/Location:_____

MEDICAL CONDITIONS **(Include past and present medical conditions, check appropriate box)**

Please list any medical changes since last visit:_____

PAST SURGERIES **(Include all surgeries in your lifetime.):**

Please list any additional surgeries since last visit: _____

ALCOHOL HISTORY

Do you currently drink alcohol regularly? Yes, currently Never/rarely
If yes, approximately how many drinks per week (beer, wine, or liquor)_____

TOBACCO HISTORY

Have you ever been a cigarette smoker? ☐ Yes ☐ No

* If yes, I smoked an average of_____packs/day for_____years. I quit in_____(year)

Do you use other tobacco products? ☐ Yes ☐ No

* If yes, please specify:_____

PAIN ASSESSMENT

Do you have any pain? ☐ Yes ☐ No If yes, location of pain: _____
If so, please rate your average amount of pain on a scale of 0 (no pain) to 10 (excruciating pain): _____

Patient Name:_____DOB:_____

REVIEW OF SYSTEMS

(Current or Recent Symptoms)

Constitutional	
Fatigue	☐ Yes ☐ No
Fever	☐ Yes ☐ No
Weight gain over 10 lbs.	☐ Yes ☐ No
Weight loss over 10 lbs.	☐ Yes ☐ No
Ear/Nose/Throat/Mouth	
Hearing loss	☐ Yes ☐ No
Dry Mouth	☐ Yes ☐ No
Respiratory (lungs)	
Difficulty breathing	☐ Yes ☐ No
Frequent coughing	☐ Yes ☐ No
Cardiovascular	
Chest pain	☐ Yes ☐ No
Leg swelling	☐ Yes ☐ No
Gastrointestinal	
Abdominal pain	☐ Yes ☐ No
Constipation	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No
Nausea/vomiting	☐ Yes ☐ No
Genitourinary	
Difficulty with erection (male)	☐ Yes ☐ No
Menstrual issues (female)	☐ Yes ☐ No
Difficulty with urination	☐ Yes ☐ No
Painful intercourse	☐ Yes ☐ No
Neurological	
Numbness/weakness	☐ Yes ☐ No
Psychiatric	
Depression	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No
Endocrine	
Hot flashes	☐ Yes ☐ No
Change in sex drive	☐ Yes ☐ No
Hematology	
Easy bruising/bleeding	☐ Yes ☐ No