Valley Urologic Associates

NEW PATIENT HISTORY AND PHYSICAL FORM

Date: _____
Name_____
Date of Birth: _____
Age: _____
Primary care Doctor: _____

Past Medical and Surgical History (Please fill out completely)

Do you have any drug **allergies**: ☐ No known Drug Allergies

☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Cipro/Levaquin ☐ Erythromycin ☐ IV Iodine ☐ Macrobid ☐ Gentamycin

Other Allergies: _____

Do you have any **medical problems** in the past or currently taking medications for: ☐ None

☐ Diabetes	☐ High Blood Pressure	☐ Coronary Heart Disease	☐ Atrial Fibrillation	☐ Asthma
☐ COPD	☐ Kidney Stones	☐ Hypothyroidism	☐ Hypercholesterolemia	☐ Stroke
☐ Gastric Reflux	☐ Gout	☐ Arthritis	☐ Morbid Obesity	☐ Seizures
☐ Seasonal Allergies	☐ Depression	☐ Cancer (Type _____)		

PLEASE LIST ANY OTHER MEDICAL PROBLEMS (NOT LISTED ABOVE) THAT YOU HAVE BEEN TREATED IN THE PAST:

Please list all your past **surgeries** : ☐ None

☐ Appendectomy	☐ Tonsillectomy	☐ Hysterectomy (uterus)	☐ Cholecystectomy (gall bladder)
☐ Spine Surgery	☐ Colonoscopy	☐ Hernia Location _____	☐ Hip Replacement
☐ Knee ☐ R ☐ L	☐ Shoulder ☐ R ☐ L	☐ Coronary Stents	☐ Coronary Bypass Graft ___ vessels
☐ C- Section	☐ Tubal Ligation	☐ Gastric Bypass	☐ Peripheral Vascular Bypass

PLEASE LIST ANY OTHER SURGICAL PROCEDURES (NOT LISTED ABOVE) THAT YOU HAVE BEEN TREATED IN THE PAST:

Please list all of your **medications/Supplements**: (include name, dosage, and how many times a day): ☐ None

Patient Name _____ DOB _____ AGE _____ DATE _____

PHYSICIAN SIGNATURE _____

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Please detail your **social** history:

Do you smoke: ☐ Yes ☐ No How many packs a day? _____ For How many years _____

Have you quit: ☐ Yes ☐ No What year _____

Do you drink alcohol ☐ Yes ☐ No How many drinks per week _____

Do you use any illicit drugs (please list) : _____

Please detail your **family** history: (any disease that your parents, grandparents, or siblings have had)

Prostate cancer ☐ Kidney Cancer ☐ Bladder Cancer ☐ Kidney Stones ☐

PLEASE LIST ANY OTHER FAMILY PROBLEMS (NOT LISTED ABOVE):

_____

_____

Are you Married ☐ Single ☐ Divorced ☐ Widowed ☐

How many pregnancies (if applicable): _____ How many children do you have: _____

What is your occupation: _____

Review of systems (please check any ***new*** symptoms that you have recently had)

Genitourinary
- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Blood in the urine
- ☐ Flank pain
- ☐ Sense of not empyting bladder
- ☐ Burning/ painful urination
- ☐ Incontinence of urine

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Headaches

Integumetary
- ☐ Skin rash
- ☐ Boils
- ☐ Persistent itch

Gastrointestinal
- ☐ Hepatitis
- ☐ Ulcer/reflux
- ☐ Constipation

Musculoskeletal
- ☐ Back pain/surgery
- ☐ Muscle disorder
- ☐ Joint disorder

Sight/Sound
- ☐ Blurred vision
- ☐ Glaucoma
- ☐ Loss of hearing/ringing

Pulmonary
- ☐ Wheezing
- ☐ Frequent Cough
- ☐ Shortness of breath

Endocrine
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Parathyroid disease

Ear/Nose/Throat
- ☐ Ear infection
- ☐ Sore Throat
- ☐ Difficulty Swallowing

Circulatory
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Varicose vein

Neurological
- ☐ Dizziness
- ☐ Migraine
- ☐ Multiple Sclerosis

Hematologic/Lymphatic
- ☐ Lymph node swelling
- ☐ Bleeding disorder
- ☐ Immune disorder (HIV)

What is your Height _____ What is your Weight: _____

Do you have a Living Will ☐ Yes ☐ No Medical Power of Attorney ☐ Yes ☐ No

Name of mPOA _____ Relationship _____ Phone _____

Patient Name _____ DOB _____ AGE _____ DATE _____

PHYSICIAN SIGNATURE _____