NORTHERN
Urology
a department of Northern Regional Hospital

NEW PATIENT MEDICAL HISTORY

Name: _____ **Age:** _____ **Date of Birth:** _____ **Sex:** **M** **F**

Reason for Visit: _____

Primary Care Provider & Date of Last Visit: _____

List Medications you are currently taking, including over-the-counter or non-prescription.

Medication Name	Strength	How often taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Allergies

☐ No known Drug Allergies ☐ No known other allergies

If you do have allergies:

☐ Drug Allergies: _____

☐ Food Allergies: _____

☐ Environmental (such as dust, tree pollen, etc.) _____

Past Medical History

Illnesses/conditions – please check the box next to any of the illnesses below that you have had or currently have. **Please check all that apply**.

		Date/Details
Anxiety	☐	Yes _____
Asthma	☐	Yes _____
Atrial Fibrillation	☐	Yes _____
Back Pain	☐	Yes _____
Bladder Cancer	☐	Yes _____
Blood Clots	☐	Yes _____
Stroke	☐	Yes _____
Chronic Lung Disease	☐	Yes _____
Depression	☐	Yes _____
Diabetes	☐	Yes _____
Diverticulitis	☐	Yes _____
Diverticulosis	☐	Yes _____
Emphysema	☐	Yes _____
Glaucoma	☐	Yes _____
Heartburn/Reflux	☐	Yes _____
High Cholesterol	☐	Yes _____
High Lipids	☐	Yes _____
Hypertension	☐	Yes _____
Hypo/Hyperthyroidism	☐	Yes _____
Irritable Bowel	☐	Yes _____
Migraine	☐	Yes _____
Heart Attack	☐	Yes _____
Kidney Stones	☐	Yes _____
Obesity	☐	Yes _____
Arthritis	☐	Yes _____
Peripheral Vascular Disease	☐	Yes _____
Rheumatoid Arthritis	☐	Yes _____
Sleep Apnea	☐	Yes _____

Past Surgical History

	Date/Details		Date/Details
Appendectomy	☐ Yes _____	Bladder Surgery	☐ Yes _____
Back Surgery	☐ Yes _____	Prostate Surgery	☐ Yes _____
Open Heart Surgery	☐ Yes _____	Ureteroscopy	☐ Yes _____
Heart Stents	☐ Yes _____	Other Surgeries:	☐ Yes _____
Gallbladder Surgery	☐ Yes _____	(if yes please explain)	
Shock Wave "Stone busting"	☐ Yes _____		
Hernia Repair	☐ Yes _____	Do you have a cardiologist? If Yes, name and last visit.	_____ _____
Hip Replacement	☐ Yes _____		
Hysterectomy	☐ Yes _____	Have you had a colonoscopy? If yes, when?	_____ _____
Knee Replacement	☐ Yes _____		
Kidney Stone Removal	☐ Yes _____		
	☐ Yes _____		

Family Medical History

Has anyone in your **IMMEDIATE** family (father, mother, sibling, grandparent, children) been diagnosed with any of the following conditions?

	Relationship
Anesthesia Problems	☐ Yes _____
Bladder Cancer	☐ Yes _____
Kidney Disease	☐ Yes _____
Kidney Stones	☐ Yes _____
Prostate Cancer	☐ Yes _____

Other not listed:

_____

Social History

Your Personal Habits: Do you…

Regularly exercise (3-4 times weekly)	☐ Yes	☐ No	(If yes, type and frequency: _____)
Use illegal drugs	☐ Yes	☐ No	(If yes, type and frequency: _____)
Use alcohol	☐ Yes	☐ No	(If yes, type and frequency: _____)
Smoke	☐ Yes	☐ No	(If yes, type and frequency: _____)
Smokeless tobacco	☐ Yes	☐ No	(If yes, type and frequency: _____)
Previous Smoker	☐ Yes	☐ No	(If yes, quit date: _____)

Do you have any advanced directives? (Living Will, Health Care Power of Attorney, Do Not Resuscitate)
If yes, please specify: _____

Preferred Language for discussing your health care: _____

Are you an organ donor? _____

Do you have any cultural, religious or personal beliefs we should be aware of?
If yes, please specify: _____

Review of Systems What problems are you having now?

		Date/Details			Date/Details
Fever	☐	Yes _____	Pain in Scrotum/Testicles	☐	Yes _____
Chills	☐	Yes _____	Difficulty with Erection	☐	Yes _____
Fatigue	☐	Yes _____	Decreased Sexual Desire	☐	Yes _____
Changes in vision	☐	Yes _____	Difficulty with Sex	☐	Yes _____
Blurred Vision	☐	Yes _____	Painful Periods	☐	Yes _____
Chest Pain	☐	Yes _____	Vaginal Discharge	☐	Yes _____
Irregular Heartbeats	☐	Yes _____	Rash	☐	Yes _____
Shortness of Breath w/ Activity	☐	Yes _____	Itching	☐	Yes _____
Swelling in Extremities	☐	Yes _____	Sores or Skin Problems	☐	Yes _____
Wheezing	☐	Yes _____	Change to moles or skin	☐	Yes _____
Flank Pain	☐	Yes _____	Numbness or Tingling	☐	Yes _____
Abdominal Pain	☐	Yes _____	Seizures	☐	Yes _____
Nausea	☐	Yes _____	Back Pain	☐	Yes _____
Vomiting	☐	Yes _____	Bone Pain	☐	Yes _____
Diarrhea	☐	Yes _____	Increased Thirst	☐	Yes _____
Constipation	☐	Yes _____	Cold or Heat Intolerance	☐	Yes _____
Changes in Abdominal Measurement	☐	Yes _____	Weight Loss or Gain	☐	Yes _____
Blood in Bowel Movements	☐	Yes _____	Anxiety	☐	Yes _____
Incontinence	☐	Yes _____	Depression	☐	Yes _____
Urinary Urgency	☐	Yes _____	Easy Bleeding	☐	Yes _____
Pain with Urination	☐	Yes _____	Easy Bruising	☐	Yes _____
Urinary Frequency	☐	Yes _____	Enlarged Lymph Nodes	☐	Yes _____
Difficulty Urinating	☐	Yes _____	Frequent Illnesses	☐	Yes _____
Decreased Stream	☐	Yes _____	Sinus/Allergy Problems	☐	Yes _____
Blood in Urine	☐	Yes _____	Dizziness	☐	Yes _____
Urination during the night	☐	Yes _____	Hot Flashes	☐	Yes _____
Blood in Semen	☐	Yes _____	Difficulty Sleeping	☐	Yes _____