ARIZONA UROLOGY

HISTORY AND PHYSICAL FORM (PATIENT)

Patient Name: _____ **DOB:** _____

Referring Physician: _____ Marital Status: _____ Age: _____

Height: _____ Weight: _____

Reason For Visit: _____

Past Medical & Social History (Please fill out completely)

Allergic to (Include Medications):

_____

_____

Surgeries:

_____

_____

Medical Illness:

_____

_____

☐ Glaucoma ☐ Tendinitis

Medications (list dose and frequency):

Name	Frequency	Name	Frequency
☐ Coumadin	_____	☐ Aspirin	_____
☐ Heparin	_____	☐ Ibuprofen	_____
☐ Plavix	_____	☐ Lipitor	_____

Other (Please List):

Name	Frequency	Name	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any medical condition that requires antibiotics prior to surgery? ☐ YES ☐ NO

(Example: Heart Murmur, Prosthetic Hips and Knees) If YES please list:

_____

_____

_____

Tobacco: ☐ Now ☐ Never ☐ In the Past, Amt Per Day_____ Age Started _____ Year Quit _____

Alcohol: ☐ Never ☐ Rare ☐Occasional ☐ Moderate ☐ Heavy, Amt/ Type per day _____

Family History & Review of System

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

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Father :_____ ☐ Prostate Cancer

Mother : _____ ☐ Kidney Stones

Brother : _____

Sister :_____

Have you experienced any of the following problems recently? **Check YES or NO**

Constitutional Symptoms			**Sight/Sound**			**Ear/Nose/Throat/Mouth**		
Fever	☐ Y	☐ N	Blurred Vision	☐ Y	☐ N	Ear Infection	☐ Y	☐ N
Chills	☐ Y	☐ N	Glaucoma	☐ Y	☐ N	Sore Throat	☐ Y	☐ N
Headaches	☐ Y	☐ N	Loss of Hearing/Ringing	☐ Y	☐ N	Difficulty Swallowing	☐ Y	☐ N
Integumentary			**Pulmonary**			**Circulatory**		
Skin Rash	☐ Y	☐ N	Wheezing	☐ Y	☐ N	Chest Pain	☐ Y	☐ N
Boils	☐ Y	☐ N	Frequent Cough	☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N
Persistent itch	☐ Y	☐ N	Shortness of Breath	☐ Y	☐ N	Varicose Vein	☐ Y	☐ N
Gastrointestinal			**Genitourinary**			**Neurological**		
Hepatitis	☐ Y	☐ N	Kidney Failure	☐ Y	☐ N	Dizziness	☐ Y	☐ N
Ulcer/Reflux	☐ Y	☐ N	Kidney Stone	☐ Y	☐ N	Migraine	☐ Y	☐ N
Constipation	☐ Y	☐ N	Urinary Tract Infection	☐ Y	☐ N	Multiple Sclerosis	☐ Y	☐ N
Musculoskeletal			**Endocrine**			**Hematologic/Lymphatic**		
Back pain/ Surgery	☐ Y	☐ N	Diabetes	☐ Y	☐ N	Lymph Node Swelling	☐ Y	☐ N
Muscle Disorder	☐ Y	☐ N	Thyroid Disease	☐ Y	☐ N	Bleeding Disorder	☐ Y	☐ N
Joint Disorder	☐ Y	☐ N	Parathyroid	☐ Y	☐ N	Immune disorder	☐ Y	☐ N

Other:

_____

_____

_____

OB/GYN History (Female Patients Only):

Menses: ☐ **YES** ☐ **NO** **Hysterectomy:** ☐ **YES** ☐ **NO** **Number of Pregnancies: _____ Live Births: _____**

Contraception: ☐ None ☐ Tubal Ligation Other: _____ Take Estrogens: ☐ YES ☐ NO

Any Other Information that you like to share:

_____

_____

_____

Patient Signature: _____ **Date: _____**