CORPUS CHRISTI UROLOGY GROUP
CONFIDENTIAL HEALTH HISTORY

Name _____ Age _____ Birthdate _____ Today's Date _____ Pharmacy _____

Gender M or F Date of last physical examination _____ PCP/ Referring Physician _____ Pharmacy's phone # _____

What is your reason for today's visit? _____

Have x-rays been taken? NO YES If yes where? _____ Ordered By? _____

ALLERGIES

_____
_____
_____
_____
_____

MEDICATIONS & SUPPLIMENTS

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

SURGERIES

Year	Hospital	Surgery type

Female Specific Surgeries

O Bladder Suspension ____
O Breast Biopsy ____
O Cesarean Section ____
O Hysterectomy ____
O Mastectomy ____
O Pubovaginal sling ____
O TAH/BSO ____
O Tubal Ligation ____
O Vaginal Hysterectomy ____

Past Medical History

O Anemia
O Angina
O Arthritis
O Asthma
O Benign prostatic hypertrophy
O Cancer
O Cerebrovascular Accident
O Chronic UTIs
O Congestive Heart Failure
O COPD
O Coronary Artery Disease
O Depression
O Diabetes
O Diverticular Disease
O GERD
O Gout
O Hepatitis C
O Hypercholesterolemia
O Hyperlipidemia
O Hypertension
O Inflammatory Bowel Disease
O Liver Disease
O Lupus
O Migraine Headache
O Myocardial infarction
O Neurologic disease
O Osteoarthritis
O Osteoporosis
O Peptic Ulcer disease
O Peripheral Vascular Disease
O Renal Disease
O Rheumatoid Arthritis
O Seizure Disorder
O Thyroid disorder
O Urolithiasis
O Valvular heart disease
O _____
O _____
O _____

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Family History – Fill in the information about your family

Relation	age	State of health living and well	age at death	Cause of death
Father				
Mother				
Brothers				
Sisters				

Check if any of your blood relatives have had any of the following:

Disease	Relationship to you	Disease	Relationship to you
O Arthritis, gout		O High Blood Pressure	
O Asthma		O Kidney Cancer	
O Breast Cancer		O Kidney Disease	
O Cancer Type:		O Kidney Stones	
O Chemical Dependency		O Prostate Cancer	
O Diabetes		O Stroke	
O Heart Disease			

FEMALES ONLY - Gynecologic History

Type of Delivery	Complications if any
O C-section O Vaginal	
O C-section O Vaginal	Date of last period __/__/____

Are you pregnant O no O yes

Social History

Questions: Please circle one for each heading below:

Marital Status

Married | Single | Divorced | Widowed | Separated | Unknown

Smoking Status

Current Every Day Smoker | Current Some Day Smoker | Former Smoker | Never Smoker | Smoker, Current Status Unknown | Unknown If Ever Smoked

Do you drink alcohol?

Yes | Not Anymore | Never Drank

How many caffeinated drinks do you have each day?

0 | 1 | 2 | 3 | 4+

Have you had a blood transfusion?

Yes | No

Language

English | Spanish | French | German | Portugese | Russian | Chinese

Race

White | Black or African American

Ethnicity

Hispanic Or Latino | Not Hispanic Or Latino

Review of Systems

Constitutional:	Fever	Headache	Chills	Weight Loss	
Eyes:	Blurry Vision				
Ears, Nose, Mouth, Throat:	Hearing Loss	Nasal Stuffiness	Sore Throat		
Cardiovascular:	Chest Pains	Swollen Ankles	Palpitations	Shortness of Breath	
Respiratory:	Chronic Cough	Wheezing	Shortness of Breath	Coughing up Blood	
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Change in Bowels	Blood in Stools	
Genitourinary:	Incontinence	Painful Urination	Blood in Urine		
Musculoskeletal:	Chronic Back Pain	Arthritis	Painful Joints		
Integumentary / Skin:	Rash	Persistent Itching	Skin Cancer History		
Neurological:	Numbness	Tingling	Dizziness	History of Seisures	Paralysis (Stroke)
Hematologic / Lymphatic:	Swollen Glands	Abnormal Bleeding	Transfusion History		