

Andrew L. Simon, M.D., F.A.C.S.

Diplomate, American Board of Urology
Urology and Genitourinary Surgery

PATIENT HISTORY

WELCOME TO OUR PRACTICE

As a new patient, please fill out the information found below to the best of your ability. A few minutes of your time carefully answering the following questions will help our urologist accurately access your problem, give better care and assist in proper insurance submission.

Patient# _____ Physician _____ Today's Date _____

Patient Name _____ Age _____ Date of Birth _____

Chief Complaint (reason for visit) _____

HISTORY OF PRESENT ILLNESS

Location _____ Quality _____
(Where is the problem or pain?) (Example abnormal color, sharp, dull or constant, etc.)

Severity _____ Duration _____
(How severe is problem or pain on a scale of 1-10, 10 being most severe) (When did problem or pain start?)

Timing _____ Context _____
(Does problem or pain occur at a specific time? after activity, eating, etc.) (Where and what were you doing at onset of problem or pain?)

Associated Signs & Symptoms _____ Modifying Factors _____

(What other associated problems have you been having?)

(What makes problem or pain worse or better?)

PATIENT MEDICAL & SOCIAL HISTORY

PATIENT MEDICAL HISTORY: Have you ever had the following (circle "yes" or "no", leave blank if uncertain):

Measles	Yes	No	Arthritis	Yes	No	Mitral Valve Prolapse	Yes	No	Blood or Plasma		
Mumps	Yes	No	Venereal Disease	Yes	No	Hernia	Yes	No	Transfusions	Yes	No
Chicken Pox	Yes	No	Anemia	Yes	No	Asthma	Yes	No	High or Low		
Whooping Cough	Yes	No	Bladder Infection	Yes	No	AIDS or HIV+	Yes	No	Blood Pressure	Yes	No
Scarlet Fever	Yes	No	Epilepsy	Yes	No	Stroke	Yes	No	ANY OTHER DISEASES		
Diphtheria	Yes	No	Hepatitis	Yes	No	Ulcer	Yes	No	(please list)	_____	
Smallpox	Yes	No	Tuberculosis	Yes	No	Thyroid Disease	Yes	No	_____		
Pneumonia	Yes	No	Diabetes	Yes	No	Kidney Disease	Yes	No	_____		
Rheumatic fever	Yes	No	Cancer	Yes	No	DATE OF LAST CHEST			DATE OF LAST MAMMOGRAM		
Heart Disease	Yes	No	Polio	Yes	No	X-RAY			(female)	_____	

Do you have any artificial joints, heart valves, heart pacemaker or defibrillator? _____

ALLERGIES: (Include allergies to medication, Iodine, X-ray contrast material, shellfish, etc.) _____

PAST SURGERY: (Include date of surgery) _____

PATIENT SOCIAL HISTORY:

Marital status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of Alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco: Never: _____ Previously, but quit _____ Current packs/day: _____
Use of Drugs: Never: _____ Type/Frequency _____

What is your occupation? (If retired, what was it prior to retirement?) _____

FAMILY MEDICAL HISTORY:

AGE	DISEASE(S)	IF DECEASED - CAUSE OF DEATH
Father _____		
Mother _____		
Siblings _____		
Spouse _____		
Children _____		

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Constitutional Symptoms

Fever Yes No
Chills Yes No
Headache Yes No
Other _____

Gastrointestinal

Abdominal Pain Yes No
Nausea/vomiting Yes No
Indigestion/heartburn Yes No
Other _____

Genitourinary

Urine retention Yes No
Painful urination Yes No
Urinary frequency Yes No
Other _____

Eyes

Blurred Vision Yes No
Double Vision Yes No
Pain Yes No
Other _____

Cardiovascular

Chest Pain Yes No
Varicose veins Yes No
High blood pressure Yes No
Other _____

Respiratory

Wheezing Yes No
Frequent cough Yes No
Shortness of breath Yes No
Other _____

Allergic/Immunologic

Hay Fever Yes No
Drug Allergies Yes No
Other _____

Integumentary

Skin rash Yes No
Boils Yes No
Persistent itch Yes No
Other _____

Hematologic/Lymphatic

Swollen glands Yes No
Blood clotting problem Yes No
Other _____

Neurological

Tremors Yes No
Dizzy Spells Yes No
Numbness/tingling Yes No
Other _____

Musculoskeletal

Joint pain Yes No
Neck pain Yes No
Back pain Yes No
Other _____

Psychologic

Memory loss/confusion Yes No
Anxiety Yes No
Depression Yes No
Other _____

Endocrine

Excessive thirst Yes No
Too hot/cold Yes No
Tired/sluggish Yes No
Other _____

Ear/Nose/Throat/Mouth

Ear infection Yes No
Sore throat Yes No
Sinus Problem Yes No
Other _____

I authorize release of information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims or insurance benefits.

X

Patient (or Guardian) Signature _____

Date _____