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UROLOGY AND GENITOURINARY SURGERY

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 Dr. Simon accurately access your problem, give better care and assist in proper insurance submission.

Patient #________________________ Today's Date ______________

Patient Name ______________________ Age______ Date of Birth______________

Chief Complaint (reason for visit) ____

HISTORY OF PRESENT ILLNESS

Location (where is the pain?) ________________Quality (sharp, dull, constant?) ________________

Severity (1-10, 10 being the worst) ____________ Duration (when problem started) ________________

Timing (does it occur at a specific time? after activity, after eating etc.) ________________________

Context (where and what were you doing at onset of pain?) ______________________________

Associated Signs & Symptoms (any other associated problems?) __________________________

Modifying Factors (what makes it worse or better?) ________________________________

PATIENT MEDICAL & SOCIAL HISTORY

Have you ever had the following? (circle "yes" or "no," leave blank if uncertain.)

Measles	Yes	No	Arthritis	Yes	No	Hernia	Yes	No
Bladder Infection	Yes	No	Anemia	Yes	No	Asthma	Yes	No
Chicken Pox	Yes	No	Small Pox	Yes	No	AIDS or HIV+	Yes	No
Whooping Cough	Yes	No	Mumps	Yes	No	Stroke	Yes	No
Scarlet Fever	Yes	No	Epilepsy	Yes	No	Ulcer	Yes	No
Diphtheria	Yes	No	Hepatitis	Yes	No	Thyroid Disease	Yes	No
Venereal Disease	Yes	No	Pneumonia	Yes	No	Mitral Valve Prolapse	Yes	No
Tuberculosis	Yes	No	Diabetes	Yes	No	Kidney Disease	Yes	No
Rheumatic Fever	Yes	No	Cancer	Yes	No	High/Low Blood Pr.	Yes	No
Heart Disease	Yes	No	Polio	Yes	No	Blood Transfusion	Yes	No

Any other diseases (please list) ____

Medication Allergies?______________ Artificial joints, heart valves, pacemaker or defibrillator?

______________ Type and Year of Placement________________

Marital Status: Single: ______ Married: ______ Separated: ______ Divorced: ______ Other: ______
Use of Alcohol: Never: ______ Rarely: ______ Moderately: ______ 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?

Constitutional Symptoms
Fever Yes No
Chills Yes No
Headache Yes No
Other____________________

Eyes
Blurred Vision Yes No
Double Vision Yes No
Pain Yes No
Other____________________

Psychological
Memory Loss Yes No
Anxiety Yes No
Depression Yes No
Other____________________

Ear/Nose/Throat/Mouth
Ear Infection Yes No
Sore Throat Yes No
Sinus Issues? Yes No
Other____________________

Neurological
Tremors Yes No
Dizzy Spells Yes No
Numbness Yes No
Other____________________

Endocrine
Thirst Yes No
Too hot/cold Yes No
Tired/Sluggish Yes No
Other____________________

Gastrointestinal
Abdom. Pain Yes No
Nausea Yes No
Indigestion Yes No
Other____________________

Cardiovascular
Chest Pain Yes No
Varicose Veins Yes No
High Blood Pr. Yes No
Other____________________

Integumentary
Skin rash Yes No
Boils Yes No
Persistent Itch Yes No
Other____________________

Respiratory
Wheezing Yes No
Cough Yes No
Short Breath Yes No
Other____________________

Musculoskeletal
Joint Pain Yes No
Neck Pain Yes No
Back Pain Yes No
Other____________________

Genitourinary
Urine Retention Yes No
Pain Urinating Yes No
Frequent Urine Yes No
Other____________________

General Allergies
Hay Fever Yes No
Other____________________

Hematologic/Lymphatic
Swollen Glands Yes No
Blood Clotting problems? 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

Patient's Complete History Form Reviewed ____________________. A. Simon, M.D., F.A.C.S