GREENWICH UROLOGICAL ASSOCIATES, P.C.
PATIENT HISTORY FORM

Last Name _____First Name _____MI _____

Date of Birth_____Appointment Date _____

Chief Complaint: (describe the reason for your visit today) _____

_____

_____

HISTORY OF PRESENT ILLNESS

Location of problem: _____
When did you first notice the problem? _____
Does anything help or make it worse? _____
Is the problem constant or variable? _____
Does the problem interfere with your normal functions? (if yes, please explain) _____

_____

Past Medical & Social History

List your active medical problems and previous diagnoses:

_____☐ Diabetes
_____☐ High Blood Pressure
_____☐ High Cholesterol
_____☐ Cancer (type) _____

List any surgeries you have had: _____

_____

List any urological problems in your family: _____

_____

List your medications: _____

_____

_____

Do you take aspirin or other blood thinners? Y N _____
Do you have allergies? Y N (if yes, list all) _____

_____

Do you smoke? Y N
If yes, how much _____
If stopped, when _____

Do you drink alcohol? Y N
If yes, how much _____
If stopped, when _____

(OVER)

REVIEW OF SYSTEMS

Do you have any problems related to the following systems? Circle Y or N
Explain any Yes answers in the space provided.

Constitutional symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Pain	Y	N
Glaucoma	Y	N
Other _____		

Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Constipation	Y	N
Diarrhea	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Other _____		

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Soar throat	Y	N
Sinus problems	Y	N
Other _____		

Genitourinary

Leaking urine	Y	N
Unable to pass urine	Y	N
Pain/Unable to have sex	Y	N
Painful urination	Y	N
Urinate frequently	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

Comments: _____

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