Name _____

Account # _____

AUNC Associated Urologists of North Carolina

Medical History Form

Chief Complaint: What is the main reason for your visit today?

_____

History of Present Illness

Location of the problem: ☐ Abdomen ☐ Back ☐ Groin ☐ Bladder

☐ Other _____

On a scale of 1-10, with 10 being the most severe,

What number best describes the problem? _____

When did you first notice the problem? _____

Does anything make the problem worse? ☐ Moving About ☐ Standing Up

☐ Urinating ☐ Other _____

Does anything help make the problem better? ☐ Change Posture ☐ Not Moving

☐ Other _____

Are there any treatments that your doctor would provide that are prohibited by your religious beliefs? ☐ No ☐ Yes If Yes, Please explain.

_____

Have the symptoms changed over time? ☐ No ☐ Yes If Yes, Please explain.

_____

How long does the problem last? ☐ _____Minutes ☐ _____Hours ☐ Constant

☐ Other _____

Is anything occurring at the same time? ☐ No ☐ Yes If Yes, Please explain.

_____

Is the problem constant? ☐ No ☐ Yes If not, please describe.

_____

Does the problem interfere with your normal function? ☐ No ☐ Yes If Yes, Please explain_____

Past Medical, Social History, Family History

Allergies: ☐ No drug allergies ☐ Latex

_____

_____

_____

_____

_____

_____

_____

Surgery History: Type / Date ☐ None

_____

_____

_____

_____

_____

_____

_____

Have you had a blood transfusion? ☐ No ☐ Yes Artificial heart valve? ☐ No ☐ Yes

Artificial joint? ☐ No ☐ Yes Antibiotic prophylaxis required? ☐ No ☐ Yes

Cardiac stent? ☐ No ☐ Yes Date _____

Medical History: List any past or current illness and start date: ☐ None

_____

_____

_____

_____

_____

_____

_____

Family History: Condition, relationship (list any serious conditions in your immediate family: e.g., diabetes, heart disease, kidney disease, kidney stones, prostate cancer, etc.): ☐ None

_____

_____

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_____

_____

_____

Medications/herbs/supplements: name, dosage, instructions — (e.g., Flomax 0.4mg once daily) ☐ None

_____

_____

_____

_____

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Associated Urologists of North Carolina

Medical History Form

Medications/herbs/supplements (continued):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Are you on a special diet? ☐ No ☐ Yes If yes, please explain.

_____

Date of last physical examination _____

What is your Height? _____ft. _____ in. **What is your Weight?** _____lbs.

Smoking History ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker

☐ Current Some Day Smoker Started Smoking _____

Stopped Smoking _____ Amt: ☐ Day ☐ Week _____

☐ Chew ☐ Dip tobacco Amt: ☐ Day ☐ Week _____

Do you drink alcohol? ☐ Yes ☐ Not anymore ☐ Never

Drinks per ☐ Day ☐ Week ☐ Month ☐ Year _____

Type: ☐ Beer ☐ Liquor ☐ Wine

☐ Present Or ☐ Prior Drinking Habits: ☐ Social ☐ Light

☐ Moderate ☐ Excessive

☐ Quit (year) _____ Drank how long? _____ Years

How much caffeine do you consume daily? Cups coffee _____ Cups tea _____

Sodas _____ # Power drinks _____ Other _____

Type and amt. chocolate _____

Review of Symptoms:

Within the past six months, any problems with any of the following? If, yes, please explain. ☐ None

Any: Fever, chills, or weight loss? ☐ No ☐ Yes

_____

Any: Blurry vision, Double Vision, or Cataracts? ☐ No ☐ Yes

_____

Any: Hearing Loss, Stuffy Nose, or Sore Throat? ☐ No ☐ Yes

_____

Any: Chest Pain, Swollen Ankles, or Irregular Heart Beats? ☐ No ☐ Yes

_____

Any: Shortness of Breath, Wheezing, or Chronic Cough? ☐ No ☐ Yes

_____

Any: Stomach Pain, Nausea/Vomiting, or Bowel Changes? ☐ No ☐ Yes

_____

Any: Back Pain, Neck Pain, or Sore Muscles? ☐ No ☐ Yes

_____

Any: Rash, Itching, or History of Skin Cancer? ☐ No ☐ Yes

_____

Any: Swollen Glands, Bleeding, or Transfusions? ☐ No ☐ Yes

_____

All Patients:

It is the responsibility of the patient to notify this office of pre-admission and/or second opinion requirements of their insurance company at the time of scheduling hospital admissions or surgery. I hereby authorize the release of any medical information pertinent to my care to my referring physician/family physician and insurance companies and accept responsibility for payment of all medical/surgical fees. I also authorize payment of insurance benefits to Associated Urologists of North Carolina, PA, except when the amount has been paid in full by me.

Signed _____

Print name _____

Date _____

Medicare Patients:

I request that payment under the Medicare Insurance Program be made directly to Associated Urologists of North Carolina, PA, on any bills for service furnished by their physicians during my lifetime. I understand that I may be held responsible for a portion of these bills after Medicare has paid the provider, or for any charges that Medicare does not cover.

Signed _____

Print name _____

Date _____