MERCY
Specialty Clinics,
Urology

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PATIENT HEALTH HISTORY

NAME: _____ DATE OF BIRTH: _____ DATE:_____

Reason for This Appointment: _____

_____

ALLERGY DRUG/ENVIRONMENTAL	REACTION

MEDICATION	DOSAGE	FREQUENCY

PAST SURGICAL HISTORY: List and date **ALL** previous surgeries:

SURGERY	DATE PERFORMED

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NAME: _____ DATE OF BIRTH: _____ DATE:_____

YOUR PAST MEDICAL HISTORY:

CARDIOVASCULAR
_____Atrial Fibrillation
_____Congestive Heart Failure
_____Coronary Artery Disease
_____Hypertension
_____Chest Pain
_____History of angioplasty/stents
_____Heart Murmur

ENDOCRINE
_____Diabetes mellitus
_____ Date Diagnosed
_____Hyperthyroid
_____Hypothyroid

GASTROINTESTINAL
_____Crohn's/Ulcerative Colitis
_____Diverticulitis
_____GERD/Reflux
_____Hepatitis
_____Stomach Ulcer

GENITOURINARY
_____AIDS/HIV
_____Bladder cancer
_____BPH
_____Herpes
_____HPV
_____Impotence
_____Kidney cancer
_____Kidney stones
_____Polycystic kidneys
_____Prostate cancer
_____Renal failure
_____Testicle cancer

HEENT
_____Blind
_____Cataracts
_____Deafness
_____Glaucoma

RESPIRATORY
_____Asthma/ COPD/ Bronchitis
_____Pulmonary Emboli
_____Sleep Apnea

MUSCULOSKELETAL
_____Arthritis
_____Fibromyalgia
_____Chronic Low Back Pain

NEURO/PSYCH
_____Alzheimer's Disease
_____Bipolar
_____Depression/ Anxiety
_____Multiple sclerosis
_____Parkinson's
_____Polio
_____Seizures
_____Spinal cord injury
_____Stroke/CVA Date:_____

YOUR SOCIAL HISTORY:

Marital Status:_____Single _____Married _____Separated _____Divorced _____Widowed
Children: Yes/No
If Yes, how many:_____
Alcohol consumption: Yes/No
If Yes, how many drinks per day: _____
Do you Smoke Now: Yes/No
If Yes, how many packs per day: _____ How many years? _____
Did you previously smoke? Yes/No
If Yes, when did you stop? _____ How many packs per day? _____
Do you take any Recreational Drugs? Yes/No
Do you drink Caffeinated Beverages? Yes/No Quantity Per Day_____
Are you sexually active? Yes/No Partners: □Male □Female □Both

YOUR OB/GYN HISTORY:

Last menstrual period _____ Pregnant Now: Yes/No
Number of pregnancies: _____ Number of deliveries: _____
Age of menopause: _____ Do you have regular periods? _____

YOUR FAMILY HISTORY:

Does anyone in your family have the following conditions?
If you are **not** adopted, indicate if father, mother, aunt, uncle, brother, sister, grandfather, or grandmother
Bladder cancer _____ Kidney Stones _____
Breast cancer _____ Kidney cancer _____
Other cancer (what type?) _____ Prostate cancer _____
Cervical/ Female cancer (what type?) _____ Testicular Cancer _____