IMS UROLOGY

The Urology Division of Integrated Medical Services (IMS)

HISTORY AND PHYSICAL FORM (PATIENT)

Date: _____ Reason for Visit: _____

Patient Name: Date of Birth: Age: Account:

Referred By: Marital Status:

Height: Weight:

Past Medical & Social History (Please fill out completely)

Allergic to (Include Medications):

Surgeries:

_____

Medical Illness:

_____

_____

☐ Glaucoma	☐ Tendinitis

Medications (list dose and frequency):

Name	Frequency	Name	Frequency
☐ Coumadin	_____	Aspirin	_____
☐ Heparin	_____	Ibuprofen	_____
☐ Plavix	_____	Lipitor	_____

Other (Please List):

Name	Frequency	Name	Frequency
			_____
			_____
			_____

Do you have any medical condition that requires antibiotics prior to surgery? ☐ YES ☐ NO

(Example: Heart Murmur, Prosthetic Hips and Knees) If YES please list:

Tobacco: Now Never In the Past Amt Per Day: Age Started: Year Quit:

Alcohol: Never Rare Occasional Moderate Heavy Amt/ Type per day:

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Family History & Review of System

Acct #:

List of all major illnesses in your immediate family

(Examples: heart disease, prostate cancer, kidney stones, kidney disease):

Father :_____ ☐ Prostate Cancer

Mother : _____ ☐ Kidney Stones

Brother : ____

Sister :_____

Have you experienced any of the following problems recently? **Check YES or NO**

Constitutional Symptoms			**Sight/Sound**			**Ear/Nose/Throat/Mouth**		
Fever	☐ Y	☐ N	Blurred Vision	Y	N	Ear Infection	Y	N
Chills	☐ Y	☐ N	Glaucoma	Y	N	Sore Throat	Y	N
Headaches	☐ Y	☐ N	Loss of Hearing/Ringing	Y	N	Difficulty Swallowing	Y	N
Integumentary			**Pulmonary**			**Circulatory**		
Skin Rash	☐ Y	☐ N	Wheezing	Y	N	Chest Pain	Y	N
Boils	☐ Y	☐ N	Frequent Cough	Y	N	High Blood Pressure	Y	N
Persistent itch	☐ Y	☐ N	Shortness of Breath	Y	N	Varicose Vein	Y	N
Gastrointestinal			**Genitourinary**			**Neurological**		
Hepatitis	☐ Y	☐ N	Kidney Failure	Y	N	Dizziness	Y	N
Ulcer/Reflux	☐ Y	☐ N	Kidney Stone	Y	N	Migraine	Y	N
Constipation	Y	N	Urinary Tract Infection	Y	☐ N	Multiple Sclerosis	☐ Y	☐ N
Musculoskeletal			**Endocrine**			**Hematologic/Lymphatic**		
Back pain/ Surgery	Y	N	Diabetes	Y	☐ N	Lymph Node Swelling	☐ Y	☐ N
Muscle Disorder	Y	N	Thyroid Disease	Y	☐ N	Bleeding Disorder	☐ Y	☐ N
Joint Disorder	Y	N	Parathyroid	Y	☐ N	Immune disorder	☐ Y	☐ N

Other:

OB/GYN History (Female Patients Only)

Menses: **YES** **NO** **Hysterectomy:** **YES** **NO** **Number of: Pregnancies_____Live Births ____**

Contraception: None Tubal Ligation Other: _____ Take Estrogens: ☐ YES ☐ NO

Any Other Information that you like to share:

_____

_____

_____

Patient Name: **Patient Signature**: _____

Updated: 1/24/2011