VCU

MCV Campus

Virginia Commonwealth University

Medical Center

In the tradition of the Medical College of Virginia

Department of Surgery
Division of Urology

ADULT PATIENT HISTORY FORM

Today's Date: _____

Name: _____ Date of Birth: _____

Primary Care Doctor: _____
Doctor's Address and Phone number: _____
_____
_____

Name, address and phone number of preferred pharmacy: _____
_____

Reason why you are here today _____

List all current medications, including how much and how often you take them:

_____
_____
_____
_____
_____
_____

Are you allergic to any medicines or food? ___ No ____ Yes
If yes, please list with type of reaction:

_____
_____
_____

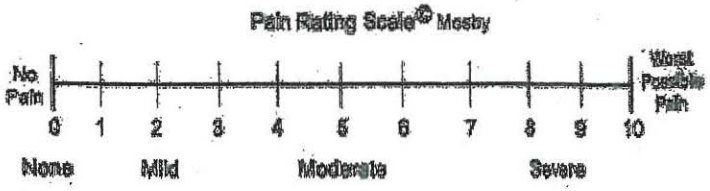
How is your health in general? ____ Excellent ____ Good ____ Fair ____ Poor

Do you smoke or use tobacco products? _____ Never _____ Quit: When? _____
_____ Yes: _____ packs per day

Do you drink alcohol? _____ No _____ Yes: _____ drinks per week

Do you use recreational/illegal drugs? _____ No _____ Yes
Have you ever used needles? _____ No _____ Yes

Are you having any pain today? _____ No _____ Yes
On a scale of 1 to 10, what is your pain level? _____



(more questions on back)

List all previous surgeries:

Date	Reason/type of surgery
_____	_____
_____	_____
_____	_____
_____	_____

Medical History (check all that apply to **YOURSELF** and/or **family members**, now or in the past)

Self	Family		Self	Family	
____	____	high blood pressure	____	____	diabetes
____	____	heart disease/heart attack	____	____	incontinence
____	____	stroke	____	____	urine infections
____	____	tuberculosis (TB)	____	____	kidney stones
____	____	lung disease	____	____	kidney cancer
____	____	HIV/AIDS	____	____	kidney failure
____	____	bleeding problems	____	____	sleep apnea
____	____	prostate cancer	____	____	hepatitis
____	____	prostate enlargement	____	____	spinal cord injury

List other conditions in YOURSELF or FAMILY: _____

_____

REVIEW OF SYSTEMS

Check any problems you are having **TODAY**. Please check all that apply.

GEN: ____ fever or chills
____ changes in appetite
____ change in weight
ENT: ____ change in vision or blurred vision
____ dry eyes or mouth
____ choking or gagging
____ colds, flu, or sinus infections
____ difficulty hearing
____ ringing in ears
CV: ____ chest pain or tightness
____ heart palpitations
RSP: ____ cough/wheeze
____ shortness of breath/difficulty breathing
GI: ____ nausea or vomiting
____ stomach pain/cramping
____ diarrhea or constipation
INT: ____ skin changes, rash, hives, or itching
END: ____ sensitivity to heat or cold
____ excessive thirst
MSK: ____ numbness/tingling in arms or legs
____ muscle/joint weakness
____ difficulty walking
____ back pain
HME: ____ abnormal bleeding or bruising
NRO: ____ headaches
____ dizziness
____ fainting
PSY: ____ changes in mood
____ depression or sadness
GU: ____ changes in urination
____ difficulty urinating
____ blood in urine
____ leaking of urine in day when awake
____ leaking of urine at night while asleep
____ pain/burning with urination
____ discharge from penis or vagina
____ sexual difficulties
____ swelling of testicles or scrotum

Describe any other concerns: _____

_____

Patient Signature: _____ Reviewed by: _____