SPRINGS UROLOGY
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DAWN SCARZELLA, M.D.
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PATIENT HISTORY FORM

DATE: ______________________________

NAME: ____ DATE OF BIRTH: _______________________ AGE: ______

EMAIL: ____

REASON(S) FOR TODAYS VISIT: ____

PRIMARY DOCTOR & PHONE #: ____

PHARMACY NAME & PHONE #: ____

REFERRING DOCTOR & PHONE #: ____

MEDICAL HISTORY

CHRONIC MEDICAL CONDITIONS (CHECK ALL THE APPLY):

- □ BLEEDING PROBLEMS
- □ KIDNEY DISEASE
- □ CARDIAC STENT PLACEMENT
- □ HEART DISEASE
- □ KIDNEY STONES
- □ CANCER ________________________________
- □ HIGH BLOOD PRESSURE
- □ OPEN HEART SUGERY
- □ OTHER ________________________________
- □ PERIPHERAL VASCULAR DISEASE
- □ PACEMAKER
- □ DEFIBRILLATOR
- □ DIABETES

SURGICAL HISTORY

***INCLUDING DATES**

- □ KIDNEY STONE SURGERY _________________________
- □ OTHER _______________________________
- □ COLONOSCOPY (DATE) _________________________
- □ OTHER _______________________________

DRUG ALLERGIES ____

ALLERGIES TO IODINE/SHELLFISH: □ YES □ NO □ OTHER: ____

MEDICATION HISTORY

–PLEASE LIST ALL OF THE MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING OVER THE COUNTER): □ NONE

NAME OF DRUG	MG DOSE	# TIMES PER DAY	NAME OF DRUG	MG DOSE	# TIMES PER DAY

ARE YOU TAKING ANY BLOOD THINNERS? □ YES □ NO

DO YOU TAKE: □ ASPRIN □ COUMADIN □ WARFARIN □ ELIQUIS □ XARELTO □ PRADAXA □ PLAVIX □ AGGRENOX □ BRILINTA

FAMILY HISTORY

FAMILY HISTORY OF: (PLEASE SPECIFY FAMILY MEMBER)

KIDNEY STONES	□ YES	□ NO	______________	CERVICAL CANCER	□ YES	□ NO	______________
KIDNEY CANCER	□ YES	□ NO	______________	HYPERTENSION	□ YES	□ NO	______________
BLADDER CANCER	□ YES	□ NO	______________	DIABETES	□ YES	□ NO	______________
UTERINE CANCER	□ YES	□ NO	______________	HEART DISEASE	□ YES	□ NO	______________
PROSTATE CANCER	□ YES	□ NO	______________	OTHER	□ YES	□ NO	______________
BREAST CANCER	□ YES	□ NO	______________	OTHER	□ YES	□ NO	______________
OVARIAN CANCER	□ YES	□ NO	______________	OTHER	□ YES	□ NO	______________

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DID YOU GET A FLU SHOT THIS YEAR? ☐ YES ☐ NO DATE: ______________

DID YOU GET A PNEUMOCOCCAL VACCINE THIS YEAR? ☐ YES ☐ NO DATE: ______________

SOCIAL HISTORY

TOBACCO USE: ☐ NON SMOKER ☐ SMOKER _____ PACKS/DAY ____ YEARS ☐ PREVIOUS SMOKER – QUIT ____________

ALCOHOL USE: ☐ NON DRINKER ☐ DRINKER ☐ SOCIAL

CAFFEINE USE: ☐ YES HOW MANY CAFFEINE DRINKS PER DAY? 0 1 2 3 4

HEIGHT _________ FEET _________ INCHES WEIGHT ____________ LB

CONSTITUTIONAL

FEVER	☐ YES	☐ NO
CHILLS	☐ YES	☐ NO
HOT FLASHES	☐ YES	☐ NO
FATIGUE	☐ YES	☐ NO
WEIGHT LOSS	☐ YES	☐ NO
WEIGHT GAIN	☐ YES	☐ NO
WEAKNESS	☐ YES	☐ NO
LOSS OF APPETITE	☐ YES	☐ NO

OPHTHALMOLOGY

CATARACTS	☐ YES	☐ NO
GLAUCOMA	☐ YES	☐ NO
BLURRY VISION	☐ YES	☐ NO
DRY EYES	☐ YES	☐ NO
VISION LOSS	☐ YES	☐ NO

ENT

TINNITIS (RINGING IN EAR)	☐ YES	☐ NO
HEARING LOSS / DIFFICULTY HEARING	☐ YES	☐ NO
SINUS PROBLEMS	☐ YES	☐ NO
NOSE BLEEDS	☐ YES	☐ NO
DRY MOUTH	☐ YES	☐ NO
DIFFICULTY SWALLOWING	☐ YES	☐ NO
SORE THROAT	☐ YES	☐ NO

CARDIOLOGY

SWELLING OF ANKLES	☐ YES	☐ NO
CHEST PAIN	☐ YES	☐ NO
DIZZINESS	☐ YES	☐ NO
IRREGULAR HEARTBEAT	☐ YES	☐ NO
PALPITATIONS	☐ YES	☐ NO

RESPIRATORY

SHORTNESS OF BREATH	☐ YES	☐ NO
WHEEZING	☐ YES	☐ NO
COUGH	☐ YES	☐ NO

GASTROENTEROLOGY

ABDOMINAL PAIN	☐ YES	☐ NO
CONSTIPATION	☐ YES	☐ NO
DIARRHEA	☐ YES	☐ NO
NAUSEA / VOMITING	☐ YES	☐ NO
HEARTBURN / INDIGESTION	☐ YES	☐ NO
BLOOD IN STOOL	☐ YES	☐ NO

MUSCULOSKELETAL

FLANK PAIN	☐ YES	☐NO
BACK PAIN	☐ YES	☐NO
SORE MUSCLES	☐ YES	☐ NO
JOINT SWELLING, STIFFNESS, PAIN	☐ YES	☐ NO

UROLOGIC

LEAKAGE OR DRIBBLING	☐ YES	☐ NO
PAINFUL URINATION	☐ YES	☐ NO
BLOOD IN URINE	☐ YES	☐ NO
FREQUENT URINATION	☐ YES	☐ NO
URGENT URINATION	☐ YES	☐ NO
NIGHTTIME URINATION	☐ YES	☐ NO
DIFFICULTY STARTING STREAM	☐ YES	☐ NO
WEAK STREAM	☐ YES	☐ NO
INCOMPLETE BLADDER EMPTYING	☐ YES	☐ NO

GYNECOLOGIC

POST MENOPAUSAL	☐ YES	☐ NO
CURRENTLY ON HORMONE REPLACEMENT?	☐ YES	☐ NO
VAGINAL DRYNESS	☐ YES	☐ NO
VAGINAL PAIN	☐ YES	☐ NO
VAGINAL DISCHARGE	☐ YES	☐ NO
VAGINAL ITCHING	☐ YES	☐ NO
PAIN WITH SEX	☐ YES	☐ NO

MALE REPRODUCTIVE

DIFFICULTY WITH ERECTION	☐ YES	☐ NO
DIFFICULTY WITH EJACULATION	☐ YES	☐ NO
DIMINISHED SEXUAL DRIVE	☐ YES	☐ NO
PENILE PAIN	☐ YES	☐ NO
TESTICULAR PAIN	☐ YES	☐ NO

ENDOCRINE

EXCESSIVE THIRST	☐ YES	☐ NO
EXCESSIVE URINATION	☐ YES	☐ NO
COLD INTOLERANCE	☐ YES	☐ NO
HEAT INTOLERANCE	☐ YES	☐ NO

HEMATOLOGIC / LYMPHATIC

BRUISES EASILY	☐ YES	☐ NO
SWOLLEN LYMPH NODES	☐ YES	☐ NO
BLOOD CLOTTING PROBLEM	☐ YES	☐ NO

DERMATOLOGY

RASH	☐ YES	☐ NO
ITCHING	☐ YES	☐ NO
DRY OR SENSITIVE SKIN	☐ YES	☐ NO
SKIN CANCER	☐ YES	☐ NO

NEUROLOGY

HEADACHE	☐ YES	☐ NO
NUMBNESS / TINGLING	☐ YES	☐ NO
WEAKNESS	☐ YES	☐ NO
DIZZINESS	☐ YES	☐ NO
SEIZURES / CONVULSIONS	☐ YES	☐ NO
ANXIETY / DEPRESSION	☐ YES	☐ NO