

PATIENT HISTORY FORM - CENTRAL OHIO UROLOGY GROUP, INC.

Last name _____ First name _____ Middle _____

Date of Birth ____/____/____ Age _____ Height _____ Weight _____

HISTORY OF PRESENT ILLNESS

CHIEF COMPLAINT – What is the reason for your visit today? _____

When did you first notice the problem? _____

Does the problem interfere with your normal functions? Yes No

Does anything make the problem worse? _____

Do you have any of the following symptoms: Blood in urine? _____ Burning with urination? _____
Getting up at night to urinate? _____ How many times? _____ Urine leakage? _____ Urinary urgency? _____
Straining to urinate? _____ Decreased urinary stream? _____ Urinary frequency? _____ how often? _____ times per day

SOCIAL HISTORY

Do you smoke? Yes No Former If yes or former, how much? _____ packs per day How long? _____ years

History of illegal drug use? Yes No

Caffeine: Yes No Type: _____ Amount per day: _____

Do you drink alcohol? Yes No Former If yes or former, how much? _____

ALLERGIES

Do you have any allergies? Please list name and reaction (example: penicillin-hives). Also list anesthesia problems:

MEDICATIONS

Current medications (please list in detail including dosages and any over the counter medications):

- | | | | |
|----------|---------------|-----------|---------------|
| 1. _____ | Reason: _____ | 6. _____ | Reason: _____ |
| 2. _____ | Reason: _____ | 7. _____ | Reason: _____ |
| 3. _____ | Reason: _____ | 8. _____ | Reason: _____ |
| 4. _____ | Reason: _____ | 9. _____ | Reason: _____ |
| 5. _____ | Reason: _____ | 10. _____ | Reason: _____ |

Do you take aspirin regularly? Yes No If yes, how much? _____

PHARMACY INFORMATION

Pharmacy Name: _____ **Phone #** _____ **Address:** _____

PATIENT SIGNATURE: _____ **DATE:** _____