**North DFW Urology**

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**MEDICAL HISTORY FORM**

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGE: \_\_\_\_\_\_\_\_\_\_ RACE: \_\_WHITE \_\_ BLACK \_\_ ASIAN \_\_ HISPANIC \_\_OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ETHNICITY: \_\_HISPANIC OR LATINO \_\_ NOT HISPANIC OR LATINO \_\_ OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MAIN COMPLAINT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­**SYMPTOMS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***HAVE YOU HAD A COLONOSCOPY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHEN: \_\_\_\_\_\_\_\_\_\_\_***

***HAVE YOU HAD THE PNEUMONIA SHOT? \_\_\_\_\_\_\_\_\_ WHEN: \_\_\_\_\_\_\_\_\_\_\_***

***DO YOU TAKE ASPIRIN ON A DAILY BASIS? \_\_\_\_\_\_\_ DOSAGE: \_\_\_\_\_\_\_\_***

**ALLERGIES:**

\_\_\_ NONE \_\_\_ SULFA **PREFERRED PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_ LATEX \_\_\_ OTHER **PREFERRED LAB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_ ADHESIVES \_\_\_ MEDICATIONS (IF YES, PLEASE LIST)

\_\_\_ PEANUTS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ SHELLFISH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS:** \_\_\_ I TAKE NO MEDICATION \_\_\_ I TAKE THE FOLLOWING MEDICATIO

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAST SURGICAL HISTORY: HAVE YOU EVER HAD A BLOOD TRANSFUSION? \_\_\_Y \_\_\_N- IF YES,DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE LIST ANY PRIOR SURGERIES**

**SURGERY SURGEON DATE WHERE/WHY SURGERY PERFORMED**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAST MEDICAL HISTORY: PLEASE CHECK ALL THAT ARE APPLICABLE**

**\_\_** ALZHEIMER’S DISEASE \_\_CLAUSTROPHOBIA \_\_FIBROMYALGIA

\_\_ANEMIA \_\_CONGESTIVE HEART FAILURE \_\_GALLBLADDER

\_\_ANXIETY \_\_CONVULSIONS \_\_GERD

\_\_ASTHMA \_\_COPD \_\_GOUT

\_\_ADHD \_\_DEPRESSION \_\_HEART ATTACK- WHEN \_\_\_\_\_\_\_\_\_\_\_

\_\_BLEEDING PROBLEMS \_\_DIABETES 1 \_\_HEPATITIS-WHAT TYPE: A B C

\_\_BLOOD CLOT IN LUNGS \_\_DIABETES 2 \_\_HIGH BLOOD PRESSURE

\_\_BLOOD CLOT IN LEG \_\_DRUG DEPENDENCY \_\_HIV/AIDS

\_\_CANCER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_EMPHYSEMA \_\_THYROID DISEASE

\_\_CARDIOVASCULAR DISEASE \_\_ENLARGED PROSTATE \_\_INTESTINAL PROBLEMS

\_\_CHICKEN POX \_\_EPILEPSY/SEIZURES \_\_KIDNEY STONES - RIGHT OR LEFT

\_\_LUPUS/IMMUNE DISEASE \_\_OSTEOPENIA \_\_OSTEOPOROSIS

\_\_PNEUMONIA \_\_PSORIASIS \_\_PSYCHIATRIC PROBLEMS

\_\_RENAL FAILURE \_\_RHEUMATOID ARTHRITIS \_\_SCOLIOSIS

**FAMILY MEDICAL HISTORY:**

**FAMILY HISTORY OF: RELATIONSHIP FAMILY HISTORY OF: RELATIONSHIP**

\_\_ADOPTED \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_EPILEPSY \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_NO FAMILY HISTORY \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_HEART DISEASE \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ARTHRITIS \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_HEMATURIA \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_BLEEDING PROBLEMS \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_HIGH CHOLESTEROL \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_BLOOD CLOTTING PROBLEMS \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_HYPERTENSION \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_CANCER-PROSTATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_KIDNEY STONES \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_CANCER-KIDNEY \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_RECURRENT UTI \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_CANCER-BLADDER \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_STROKE/TIA \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_CROHNS DISEASE \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_DIABETES \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

**MARITAL STATUS WORK STATUS SUBSTANCE USE**

\_\_MARRIED \_\_WORK FULL TIME \_\_FORMER SMOKER \_\_\_\_ PKS DAY\_\_\_\_\_\_QUIT DATE

\_\_SINGLE \_\_WORK PART TIME \_\_CURRENT SMOKER\_\_\_\_PKS PER DAY

\_\_DIVORCED \_\_DISABLED \_\_NEVER SMOKED

\_\_WIDOWED \_\_RETIRED-OCCUPATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_SMOKELESS TOBACCO \_\_YES \_\_NO

\_\_UNEMPLOYED \_\_ALCOHOL INTAKE \_\_\_\_\_ DRINKS PER WEEK

\_\_OTHER \_\_\_\_\_\_\_\_\_ \_\_ILLICIT DRUG USE

**OCCUPATION OR FORMER OCCUPATION IF RETIRED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

DO YOU DRINK CAFFEINATED DRINKS \_\_\_Y \_\_\_N WHAT TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOW MANY PER DAY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_