CHRISTIE CLINIC
Medicine for Your Life

Urology Patient History
Urology Department (217)366-1240

Patient name_____ Date_____
Age_____ Occupation_____ Referred By_____ Other MDs_____
What urinary symptoms do you have at this time or what is the purpose of this visit? _____
_____
_____
What makes the symptoms better or worse? _____
When did the symptoms begin? _____
How do your symptoms change with time? _____
Have you ever had symptoms of this nature before? _____
Do you have any other urologic diseases? Yes No Explain: _____
_____
Have you had urinary tract surgery? Yes No Explain: _____
_____

Do you have any of these symptoms or diseases?

Urgency of urination	Yes	No	Palpitations or irregular heartbeat	Yes	No
Frequency of urination	Yes	No	Hypertension	Yes	No
Blood in urine	Yes	No	Heart Valve disease	Yes	No
Pain on urination	Yes	No	Chest pain	Yes	No
A weak urinary stream	Yes	No	Cough	Yes	No
Incontinence of urine	Yes	No	Shortness of breath	Yes	No
Get up at night to urinate	Yes	No	Weakness	Yes	No
How many times typically? _____			Lightheadedness	Yes	No
Unusual vaginal discharge	Yes	No	Eye discharge	Yes	No
Vaginal dryness	Yes	No	Eye redness	Yes	No
Back pain	Yes	No	Sore throat	Yes	No
Bowel problems	Yes	No	Liver disease or jaundice	Yes	No
Lower abdominal pain	Yes	No	Rash	Yes	No
Irritable bowel syndrome	Yes	No	Headache	Yes	No
GERD or Heartburn	Yes	No	Stroke	Yes	No
Pancreatitis	Yes	No	Depression	Yes	No
Diverticulitis	Yes	No	Anxiety	Yes	No
Weight Loss	Yes	No	Diabetes	Yes	No
Bruise excessively	Yes	No	Swollen lymph nodes	Yes	No
Bleeding problems	Yes	No	Spleen removed	Yes	No

List any **medication allergies:** _____
List any **medications you are currently taking** including over the counter medicines: _____
_____
List any **medical conditions or illnesses:** _____
_____
List any **operations** (dates):_____
_____
List any inheritable diseases, cancers, kidney stones or bleeding tendencies in your family: _____
_____
Do you have children? Yes No How many? _____
Have you ever smoked? Yes No How much per day? _____ For how long? _____ Quit when?_____
Do you drink alcohol? Yes No How many drinks? _____ per day, week or month