El Dorado Urology & Prostate Center
New Patient History Form

TODAY'S DATE _____/_____/_____ PATIENT DATE OF BIRTH _____/_____/_____ PATIENT MRN _____

LAST NAME_____FIRST NAME_____MIDDIE INITIAL_____

Pharmacy Preference _____
Name Location

Reason for today's visit (Please Describe in Detail)

_____

_____

Surgical History: If none check here ☐
(Please list the Operations, Reason, Hospital/Surgeon and Date if applicable)

_____

_____

Allergies: If none check here ☐ If you are allergic to Iodine or X-ray dye, check here ☐
(Please list all Medication, Food, or other Allergies and the reaction you have to them)

_____

_____

Current Medications:

Medication Name	Dose	How often?

Social History

Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Living Arrangement ☐ With Spouse ☐ Alone ☐ With Child(ren) ☐ With Relatives ☐ Care Facility ☐ Other

Children ☐ No Children ☐ Yes Number of Children _____

Tobacco Use ☐ Current ☐Former (date stopped)_____ ☐Never
Number of years Use_____ Pack per Day_____
Type ☐ Cigarettes ☐ Cigars ☐Pipe ☐Smokeless Tobacco Products

Alcohol Use ☐ Never ☐Social ☐Currently Uses ☐Stopped Alcohol Use (Year)_____
Type ☐ Wine ☐Beer ☐Spirits
Drinks per Day_____ Drinks per Week_____ Drinks per year_____

Illicit Drugs ☐ Yes ☐ No

Transfusion History ☐ No Transfusion History ☐ Transfused/date of most recent_____
Blood Product Type _____ Units Given_____
Transfusion Reaction ☐ No ☐ Yes/Type_____

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Primary Language _____

Occupation Primary: _____Secondary: _____

Occupational Exposure ☐No ☐Yes/Type _____ Date_____

Family History

Does anyone related to you have a history of:

Mother ☐ Alive (age) _____ ☐Deceased (age) ☐Cause of Death_____
Health Issues ☐Yes ☐ No

Father ☐ Alive (age) _____ ☐Deceased (age) ☐Cause of Death_____
Health Issues ☐Yes ☐ No

Brother(s) ☐ Alive (age) _____ ☐Deceased (age) ☐Cause of Death_____
Health Issues ☐Yes ☐ No

Sister(s) ☐ Alive (age) _____ ☐Deceased (age) ☐Cause of Death_____
Health Issues ☐Yes ☐ No

Children ☐Alive – one child (age)_____ ☐Alive – multiple (ages) _____
☐Deceased Child/Children (age)_____ Health Issues ☐Yes ☐ No

Family Cancer History ☐ None ☐Unknown
Positive Family History of Cancer ☐Breast ☐Prostate ☐Ovarian ☐Uterine ☐Brain ☐Lung
☐Pancreas ☐Colon Cancer ☐ Other _____

GYN History

Menarche Age at Menarche_____ Cycle and days of Menses _____
☐Menopause(age) _____

Birthing History Age at first pregnancy _____ ☐No Pregnancies
Number of pregnancies_____ Number of live births _____

Cramps ☐Yes ☐No

Estrogen Use ☐No ☐Yes/estrogen used_____ Years of estrogen use_____

Health Maintenance

Colonoscopy ☐Never ☐Date of Last _____

Prostate Exam ☐Never ☐Date of Last _____

PSA ☐Never ☐Date of Last _____

Mammogram ☐Never ☐Date of Last _____

Bone Density ☐Never ☐Date of Last _____

Review of Systems:

Are you **currently** experiencing any of the following?

CONSTITUTIONAL	YES	NO	GASTROINTESTINAL	YES	NO
Anorexia			Nausea		
Fatigue			Vomiting		
Generalized Weakness			Difficulty Swallowing		
Altered Taste			Heartburn		
Weight Loss			Abdominal Pain		
Fever			Diarrhea		
Chills			Constipation		
Sweats			Blood in Stools		
Night Sweats			Dark Stools		

Freq or Severe Infections			**GENITOURINARY**		
EYES			Pain with Urination		
Blurred Vision			Urination at Night		
Double Vision			Hesitancy		
Excessive Tearing			Urgency		
Dry Eyes			Incontinence		
ENT			Blood In Urine		
Hearing Loss			Frequent Urination		
Ringing in Ears			Change in Stream		
Sinus Tenderness			Hernia		
Mouth Sores			Impotence		
Dry Mouth			Scrotal Mass		
CARDIOVACULAR			Scrotal Pain		
Chest Pains			STD		
Palpitations			**MUSCULOSKELETAL**		
Swollen Ankles			Bone Pain		
RESPIRATORY			Muscle Pan		
Shortness of Breath			Joint Pain		
At Rest?			Back Pain		
With Activity?			Joint Swelling		
Sputum			Limited Range of Motion		
Coughing up blood?					
SKIN	**YES**	**NO**	**NEUROLOGICAL**	**YES**	**NO**
Rash			Headache		
Persistent itching			Neuropathy		
Skin Lesions			Weakness		
Dry Skin			Paralysis		
GYN			Tremors		
Abn Vaginal Bleeding			Seizures		
Vaginal Dryness			Speech Impairment		
Vaginal Discharge			Dizziness		
Pelvic Pain					

Patient Signature _____ Date_____