Randolph Health
Urology

Revised Adult History-pg 1

Patient's Name _____ Male / Female Date of Birth _____

Primary Care Physician Name _____ Preferred Pharmacy_____

PAST MEDICAL & FAMILY HISTORY (Please check if you or your family members have had any of the following diseases)

	Self	Father	Mother	Grandparent (Maternal)	Grandparent (Paternal)	Brother	Sister
Diabetes	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Asthma/Emphysema	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐
Other Cancer _____	☐	☐	☐	☐	☐	☐	☐
Sickle Cell	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Kidney/Bladder Problems	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐
Hepatitis or Jaundice	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
Positive HIV/AIDS	☐	☐	☐	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	☐	☐	☐
Other Illness _____	☐	☐	☐	☐	☐	☐	☐

CURRENT MEDICATIONS (Name of prescription and over the counter medications & dosage)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Do you take any:

☐ Herbal Products
☐ Vitamins
☐ Minerals ☐ Aspirin

ALLERGIES & REACTIONS ☐ No known Allergies

Drugs _____

Food _____ Other _____

SOCIAL HISTORY

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

Living Situation: ☐ Lives Alone ☐ With Spouse ☐ With Parents ☐ Nursing Home/Assisted Living ☐ Other

Number of Children: _____

Employment: ☐ Full-time ☐ Part-time ☐ Disabled ☐ Retired ☐ Unemployed

Occupation _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

TOBACCO & ALCOHOL HISTORY

Recreational Drugs:

Do you currently use recreational drugs? □ Yes □ No If so, type: _____

Alcohol:

How much alcohol do you drink? □ None □ Rarely □ 1-7 drinks/week □ 8-14 drinks/week □ more than 14/week

Have you had a problem with alcohol in the past? □ Yes □ No

Tobacco:

Do you use now? □ Yes □ No Type _____ Would you like to quit? □ Yes □ No

Have you used in the past? □ Yes □ No How many years did you use? _____ When did you quit? _____

Caffeinated Beverages: Cups/glasses per day_____

PAST SURGERIES (Please list all past surgeries and the year performed)

□ Appendix _____ year □ Gallbladder _____ year □ Thyroid _____ year □ Hysterectomy _____ year

□ Hernia _____ year □ Heart _____ year □ Lung _____ year □ Tonsillectomy _____ year

Other _____

RECENT HOSPITALIZATIONS (Other than above surgeries or child birth)

Year	Reason	Year	Reason

HEALTH MAINTENANCE

Men Do you do self-testicular exams? □ Yes □ No Date of last PSA _____

Women Date of last menstrual cycle _____ Age of menopause _____

Pregnancies: Total # _____ Deliveries _____ Miscarriages _____

Date of last Bone Density test _____

All *(Year of last)* Colonoscopy (If over 50) _____

PERSONAL SAFETY

Have you participated in any high risk behaviors that could put you at risk for HIV/AIDS such as: IV drug use, multiple sex partners or same sex partners? □ Yes □ No

CONSTITUTIONAL

What are you being seen for today? _____

IF YOU HAVE A LIVING WILL OR HEALTHCARE POWER OF ATTORNEY, PLEASE PROVIDE US WITH A COPY.