**Oconee Urology, P.C. 1217 Columbia Drive, Milledgeville, Georgia 31061**

# Patient History

**Family MD:**_____**Referring MD:**_____
**Date of Birth:** _____|_____|_____**Date of Last Physical Exam:**_____|_____|_____
**Appointment Date: calucasn on the kidney care improvement plus Appointment Time:**

**Appointment For: New Patient Visit**

**Nurse will complete: BP** _____ **Pulse** _____ **Resp** _____ **Age** _____

**Chief Complaint: (What is the main reason for your visit today?)**_____
_____

**History of Present Illness:**
**How long ago did your problem start?**_____

**Does anything make the problem better?**
( )Moving around ( )Standing ( )Lying Down ( )Medications– Name _____
( )Other:_____

**Does anything make the problem worse?**
( )Moving around ( )Standing ( )Lying Down
( )Other:_____

**On a scale of 1 to 10, with 10 being the most severe, (check) thenumber that best describes the problem.**
( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7 ( )8 ( )9 ( )10

**How long does the problem last? (check)**
( )30 minutes or less ( )1 hour or more ( )Always there

**Is the problem constant or variable?** _____
**If it is variable, how does it change?**_____

**Is anything else occurring at the same time? Please (check)** ( )YES ( )NO
**If yes, please explain:** _____
_____

**Does the problem interfere with your normal functions? Please (check)** ( )YES ( )NO
**If yes, please explain:** _____
_____

**Patient Signature**_____ **Date:** _____|_____|_____

**Oonee Urology, P.C. 1217 Columbia Drive, Milledgeville, Georgia 31061**

**NAME:**

***Past Medical History***

**Conditions (please check all boxes that apply)**

| | | | |
|---|---|---|---|
| ( )AIDS | ( )Chicken Pox | ( )Herpes | ( )Parkinsons Disease |
| ( )Alcoholism | ( )Chlamydia | ( )High Blood Pressure | ( )Pneumonia |
| ( )Anemia | ( )Diabetes | ( )High Cholesterol | ( )Polio |
| ( )Anorexia | ( )Emphysema | ( )HIV Positive | ( )Prostate Problems |
| ( )Appendicitis | ( )Epilepsy | ( )Kidney Stones | ( )Rheumatic Fever |
| ( )Arthritis | ( )GenitalWarts | ( )Kidney Disease | ( )Scarlet Fever |
| ( )Asthma | ( )Glaucoma | ( )Kidney Infection | ( )Schizophrenia |
| ( )Bladder Infection | ( )Goiter | ( )Liver Disease | ( )Sickle Cell Disease |
| ( )Bronchitis | ( )Gonorrhea | ( )Malaria | ( )Seizures |
| ( )Bulimia | ( )Gout | ( )Measles | ( )Stomach Ulcer |
| ( )Bipolar Disorder | ( )Heart Attack | ( )Migraines | ( )Stroke |
| ( )Cancer | ( )Heart Disease | ( )Multiple Sclerosis | ( )Thyroid Disease |
| ( )Cataracts | ( )Hepatitis | ( )Mumps | ( )Tuberculosis |
| ( )Chemical Dependency | ( )Hernia | ( )Paralysis | ( )Typhoid Fever |

**Medications** (list those you are presently taking - Prescription and Non-Prescription) | **Allergies to Medications**

_____ | _____
_____ | _____
_____ | _____
_____ | _____
_____ | _____
_____ | _____

**Surgery/Hospitalizations** | **Pregnancy History**

| Year | Hospital | Reason / Operative Procedure | Year of Birth | Sex | Complications |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Patient Initials:** _____ **Date:** _____|_____|_____

**Oconee Urology, P.C. 1217 Columbia Drive, Milledgeville, Georgia 31061**

**NAME:**

***Past Medical History Continued*** **Please (check) any that apply to you.**

**Blood Transfusion** ( )NO

**Social History:** ( )Married ( )Separated ( )Divorced ( )Widowed
( )Occupation _____( )Retired
( )Military Service ( )Overseas Service
( )Exposure to Hazardous Chemicals

**Habits:** ( )Coffee ( )Tea ( )Soft Drinks
( )Cigarettes ( )Cigars ( )Pipe ( )Smokeless Tobacco
( )Alcohol ( )Recreational Drugs ( )IV Drugs

***Family History***

| Relation | Age | State of Health | Age at Death | Cause of Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| | | | | |
| Brothers | | | | |
| | | | | |
| | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Check if your blood relatives had any of the following:**

| DISEASE | RELATIONSHIP TO YOU |
|---|---|
| ( )Arthritis, Gout | _____ |
| ( ) Asthma Hay Fever | _____ |
| ( ) Cancer | _____ |
| ( ) Chemical Dependency | _____ |
| ( ) Diabetes | _____ |
| ( ) Heart Disease/Strokes | _____ |
| ( ) High Blood Pressure | _____ |
| ( ) Kidney Disease | _____ |
| ( ) Tuberculosis | _____ |
| ( ) Kidney Stones | _____ |
| ( ) Prostate Cancer | _____ |
| ( ) Other | _____ |

**Patient Initials:**_____

**Date** _____|_____|_____

Oconee Urology, P.C. 1217 Columbia Drive, Milledgeville, Georgia 31061

NAME:

*Review of Symptoms* Check symptoms you currently have or recently have had.

**1.Allergy/Immunology**
( )Hay Fever
( )Other _____

**2. Eyes**
( )Blurred Vision
( )Double Vision
( )Flashes
( )Halos

**3.Respiratory**
( )Shortness of Breath
( )Wheezing
( )Chronic Cough
( )Cough up Blood

**4.Cardiovascular**
( )Chest Pain
( )IrregularHeartbeat
Swelling Legs/Ankles
( )Rapid Heart Beat
( )Varicose Veins

**5.Skin**
( )Rash
( )Boils
( )Hives
( )Changes in Mole
( )Sore that won't heal

**6.Musculoskeletal**
( )Pain, Weakness, Numbness
( )Hands ( )Shoulders
( )Arms ( )Hips
( )Back ( )Feet

**7.Genitourinary**
( )Urgency ( )Weak Urinary Stream
( )Frequency ( )Hard to Start Stream
( )Blood in Urine
( )Kidney/Bladder Pain
( )Incontinence

**8.Endocrine**
( )Excessive Hunger
( )Excessive Thirst
( )Tired/Sluggish
( )Too Hot or Cold

**9.Hematologic/Lymphatic**
( )Bruise Easily
( )Bleed Easily
( )Blood Clots
( )Swollen Glands

**10.Psychologic**
( )Depression
( )Anxiety
( )Nervousness
( )Suicidal
( )Psychiatric Care

**11.Neurological**
( )Dizziness
( )Fainting
( )Numbness
( )Tremors
( )Tingling

**12. General**
( )Chills
( )Fever
( )Forgetfulness
( )Headache
( )Sleep Loss
( )Loss ofWeight
( )Night Sweats
( )Poor Appetite

**13. ENT**
( )Bleeding Gums
( )Difficult Swallowing
( )Earache
( )Ear Drainage
( )Sore Throat
( )Hoarseness
( )Hearing Loss
( )Nose Bleeds
( )Ringing in Ears
( )Sinus Problems

**14.Gastrointestinal**
( )Nausea
( )Vomiting
( )Constipation
( )Diarrhea
( )Gas
( )Indigestion
( )Stomach Pain
( )Heartburn
( )Bowel Incontinence
( )Rectal Bleeding
( )Vomiting Blood

Patient Initials: _____ Date _____|_____|_____

Oconee Urology, P.C. 1217 Columbia Drive, Milledgeville, Georgia 31061

**NAME:**

***Review of Symptoms Continued*** **Please check any that apply to you.**

**15.Reproductive**

| | |
|---|---|
| **( ) Pap Smear** | **( )Lump in Testicles** |
| **( ) Bleeding Between Periods** | **( )Nipple Discharge** |
| **( )Breast Lump** | **( )Painful Intercourse** |
| **( )Erection Problems** | **( )Penis Discharge** |
| **( )Ejaculation Problems** | **( )Genital Skin Lesion** |
| **( )Extreme Menstrual Pain** | **( )Vaginal Discharge** |
| **( )Hot Flashes** | **( )Penis Curves** |
| **( )Infertility** | |

**Date Last Menstrual Period:** _____/_____/_____

**Date Last Pap Smear:** _____/_____/_____

**Are You Pregnant:** **( ) Yes ( ) No**

**Patient Signature:**_____**Date** _____/_____/_____

**Physician Signature:**_____ **Date** _____/_____/____