OHSUHealth
Hillsboro Medical Center

Patient history form

Westside Urology Associates | 333 SE 7th Ave, Ste 4500 | Hillsboro | OR | 97123 | Tel: (503) 648-6611

Name: ______________________________ Date: ______________

Height: __________ Weight: __________

History of present illness

Reason(s) for this visit: ______________________________

Duration of above complaint (*please indicate number*): _______ week's _______ month's _______ years

Have you been treated for this condition in the past? ❒ No ❒ Yes If yes, please explain: ______________

____

Frequency of urination: daytime __________ nighttime __________

Strength of stream: ❒ normal ❒ decreased ❒ poor

Are you experiencing any of the following symptoms (*please circle Yes or No*)?

Symptom				Symptom			
Blood in urine	Y	N	________	Leakage of urine	Y	N	________
Urinary infections	Y	N	________	Interruption of stream	Y	N	________
Kidney or bladder stone	Y	N	________	Split stream	Y	N	________
Burning or pain with urination	Y	N	________	Dribbling after urination	Y	N	________
Difficulty starting urination	Y	N	________	Urgent urination	Y	N	________

Have you had any x-rays related to this condition? Y N If yes, when and where were these performed?

____

Past medical history

Have you ever had any of the following (*please circle Yes or No*)?

Condition				Condition			
Heart disease	Y	N	________	Cancer	Y	N	________
High blood pressure	Y	N	________	Blood transfusion	Y	N	________
Lung disease (COPD)	Y	N	________	Kidney problems	Y	N	________
Diabetes	Y	N	________	Gastrointestinal disease	Y	N	________
Glaucoma	Y	N	________	Bleeding problems	Y	N	________
Hepatitis	Y	N	________	Artificial joint	Y	N	________

Other illness not listed: ______________________________

Past surgical history

Please list all of the operations that you have had:

1. ______________________________ Date: ______________
2. ______________________________ Date: ______________
3. ______________________________ Date: ______________
4. ______________________________ Date: ______________

Social history

Do you or have you used tobacco? ☐ No ☐ Yes How many packs per day: _____ how long: _____ year quit: ______

Do you drink alcohol? ☐ No ☐ Yes How much: ______________ how long: ____________ year quit: ____________

How many glasses do you drink daily: Coffee _________ Water _________ Tea ________ Soda ________ Juice _______

Medications (*please include aspirin and vitamins*):

	Name	Dosage	Frequency		Name	Dosage	Frequency
1.				5.			
2.				6.			
3.				7.			
4.				8.			

Allergies (*please list medications and type of reaction*):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Do you have a family history of the following?

Father Mother Brother Sister Son Daughter Other: ______________________

Bleeding disorder ______________________

Diabetes ______________________

Gastrointestinal complication ______________________

Heart disease ______________________

Kidney disease ______________________

Kidney stone ______________________

Prostate cancer ______________________

UTI (urinary tract infection) ______________________

For women only

1. How often do you leak urine (*please circle the degree*)? ______________________

   0 (Never) 1 2 3 4 5 (All the time)

2. How much urine do you usually leak?

   0 (None) 1 2 3 4 5 (Large amount)

3. Overall, how much does leaking interfere with your lifestyle?

   0 (Not at all) 1 2 3 4 5 6 7 8 9 10 (A great deal)

4. When do you leak urine?

   ☐ Never
   ☐ For no obvious reason
   ☐ While sleeping
   ☐ Before reaching toilet
   ☐ Washing hands
   ☐ All the time
   ☐ Cough/sneeze
   ☐ Lifting or exercise
   ☐ When standing
   ☐ Unlocking front door

Review of systems

Please circle YES (Y) or NO (N). Please explain any YES answers in the space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Night sweats	Y	N
Weight loss/ anorexia	Y	N
Headache	Y	N

Other: ______________________________

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other: ______________________________

Allergic/ Immunologic

Hay fever	Y	N
Drug allergies	Y	N

Other: ______________________________

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Other: ______________________________

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other: ______________________________

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Other: ______________________________

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other: ______________________________

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other: ______________________________

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other: ______________________________

Ear/ Nose/ Throat/ Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N

Other: ______________________________

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other: ______________________________

Respiratory

Wheezing	Y	N
Persistent cough	Y	N
Shortness of breath	Y	N
Bloody sputum	Y	N

Other: ______________________________

Hematological/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other: ______________________________

Psychological

Are you generally satisfied with life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other: ______________________________

Authorization to communicate protected health information

In general, the HIPAA privacy policy rule gives the individuals the right to request restrictions on uses and disclosures of health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means.

I wish to be contacted in the following manner (check all that applies):

- ☐ Home telephone: ______________________________
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with call back number only

- ☐ Other telephone: ______________________________
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with call back number only

- ☐ Written communication
  - ☐ Okay to mail to my home address

- ☐ Okay to discuss personal health information with:

  ____

  ____

  ____

This authorization will be ongoing, but can be amended or revoked at any time by signing a new authorization form.

______________________________ ______________

Patient signature Date

______________________________ ______________

Print name Date of Birth

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