KCUC
KANSAS CITY UROLOGY CARE, P.A.

Patient History Form for Use with EMR

This is a confidential record and will be kept in your electronic patient chart

Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE _____ / _____ / _____ **DATE OF BIRTH** _____ / _____ / _____

LAST NAME _____ **FIRST NAME** _____ **M.I.** ___

REFERRING PHYSICIAN _____ **PRIMARY CARE PHYSICIAN** _____

Reason for seeing the physician on the first visit: _____

Have you been exposed to or currently have TB (tuberculosis)? ***Y*** ***N***

ALLERGIES/REACTIONS TO ANY MEDICATION OR FOOD:

_____

_____

LIST CURRENT MEDICATIONS *(include over the counter items such as aspirin)*

MEDICATION/DOSAGE	MEDICATION/DOSAGE
1. _____	7. _____
2. _____	8. _____
3. _____	9. _____
4. _____	10. _____
5. _____	11. _____
6. _____	12. _____

OVER-THE-COUNTER SUPPLEMENT MEDICATIONS *(if nothing marked then NONE APPLY)*

Echinacea	Metabolife	Garlic	Ginkgo	Ginseng
Kava	St. Johns Wort	Valerian	Fish Oil	Vitamin E

Other_____ Other_____

Are you required to take antibiotics with dental work? N Y

LAST NAME _____ FIRST NAME _____ DOB _____

PAST SURGICAL HISTORY – Check previous surgeries & provide date *(if nothing marked then NONE APPLY)*

__Bladder augmentation_____ __Adrenalectomy_____

__Bladder suspension_____ __Appendectomy_____

__Cystectomy_____ __Back surgery_____

__Cystoscopy_____ __Breast biopsy_____

__Green light PVP_____ __CABG_____

__Hydrocele repair_____ __Cesarean section_____

__Kidney Stone Removal_____ __Cholecystectomy_____

__Laparoscopy_____ __Colon surgery_____

List type of Laparoscopy __Coronary Stent_____

__Lithotripsy_____ __Gastric bypass_____

__Nephrectomy_____ __Heart Valve Replacement_____

__Pacemaker_____ __Hernia repair_____

__Percutaneous nephrolithotomy_____ __Hip replacement_____

__Pubovaginal sling_____ __Hysterectomy_____

__Tubal ligation_____ __Knee replacement_____

__Ureteroscopy-stent_____ __Mastectomy_____

__Vasectomy_____ __Other_____

PAST MEDICAL HISTORY – Check any previous past medical problems *(if nothing marked then NONE APPLY)*

___ Anemia ___ Diabetes 1 OR 2 (circle one) ___ Migraine headaches

___ Angina ___ Diverticular disease ___ Multiple Sclerosis

___ Arthritis ___ GERD ___ Myocardial Infarction

___ Asthma ___ Gout ___ Osteoarthritis

___ BPH ___ Hepatitis C ___ Osteoporosis

___ Cancer_____ ___ Hypercholesterolemia ___ Peptic Ulcer Disease

List type of cancer ___ Hyperlipidemia ___ Peripheral Vascular Disease

___ Cerebrovascular accident ___ Hypertension ___ Renal Disease

___ Chronic UTIs ___ Hypothyroid ___ Dialysis

___ Congestive heart failure ___ Inflammatory bowel disease (___Hemo ___Peritoneal)

___ COPD ___ Liver disease ___ Rheumatoid Arthritis

___ Coronary artery disease ___ Lupus ___ Seizure Disorder

___ Depression ___ Urolithiasis

Other_____ Other_____

LAST NAME _____ FIRST NAME _____ DOB _____

FAMILY HISTORY ***Indicate*** *what family member has the condition* ***(FATH, MOTH, SIS, BRO, DAU, SON)***

Anesthesia Problems____ Heart Problems____ Kidney Stones____ Strokes____

Bladder Cancer____ High Blood Pressure____ Lung Problems____ Unknown History____

Bleeding Disorders____ Kidney Cancer____ Polycystic Kidneys____

Diabetes____ Kidney Disease____ Prostate Cancer____

Other Cancer (specify) _____

SOCIAL HISTORY: Please Circle Answers

Marital Status: Married Single Divorced Widowed Legally Separated Annulled Life Partner Unknown

Smoking Status: (please circle and answer as appropriate)

Current Every Day Smoker? When did you start smoking?_____Packs smoked per day?_____

Current Some Day smoker? When did you start smoking?_____ Packs smoked per day? _____

Former Smoker? When did you quit? _____ Packs smoked per day? _____ How long did you smoke?____

Never Smoked Smoker, Current Status Unknown Unknown if ever smoked

Do you use Smokeless Tobacco? (please circle) Yes No

How many caffeinated drinks do you have each day? (please circle) 0 1 2 3 4+

Do you drink alcohol? (please circle) Yes, how much do you drink_____ Not Anymore Never Drank

Type of alcohol consumed? **(please circle)** Beer Liquor Wine

Drinking habits? (please circle) Social Light Moderate Excessive

Do you use recreational drugs? (please circle) Yes No

Have you had a blood transfusion (please circle) Yes No

Race: (please circle) American Indian or Alaska Native Black or African American Eskimo

Native Hawaiian or Other Pacific Islander White Asian Declined to Specify Hispanic or Latino

Unknown

Language: (please circle) English Arabic Chinese Declined French German Italian Japanese

Other Portuguese Russian Spanish Vietnamese Other _____ **Ethnicity:**

(please circle) Hispanic or Latino Not Hispanic or Latino Declined Unknown

Current or Former Occupation? _____

LAST NAME _____ FIRST NAME _____ DOB _____

REVIEW OF SYSTEMS – **Please circle any symptoms you are currently experiencing.**

Constitutional:	Fever	Chills	Weight Loss	
Eyes:	Blurry Vision	Cataracts	Glaucoma	
Ears, Nose, Mouth, Throat:	Hearing Loss	Nasal Stuffiness	Sore Throat	
Cardiovascular:	Chest Pains	Swollen Ankles	Irregular Heartbeat	
Respiratory:	Shortness of Breath	Wheezing	Chronic Cough	Known TB Exposure
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Change in Bowels	
Genitourinary:	Incontinence	Painful Urination	Blood in Urine	Erectile Dysfunction
Musculoskeletal:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles	
Integumentary/ Skin:	Rash	Persistent Itching	Skin Cancer History	
Neurological:	Numbness	Tingling	Dizziness	
Hematologic/Lymphatic:	Swollen Glands	Abnormal Bleeding	Transfusion History	
Psychiatric:	Anxiety	Depression		

APPROXIMATE HEIGHT: _____ **WEIGHT:** _____

Physician Signature:_____ Date: _____

9/16/2014