CWUA
Central Wyoming
Urological Association

Patient History Form

1416 E. A St. Suite 101
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Patient Name: _____ Age: _____ Today's Date:_____

Present Illness: Concerns or Reason for Today's Visit? _____
Location of problem (abdomen, flank, etc.) _____
Describe the problem _____
Severity of problem (scale of 1-10) _____
When did you first notice the problem? _____
How long does the problem last? _____
Is the problem constant or variable? Related to anything else? _____
Does anything else occur at the same time (nausea, fevers, etc.) _____
Does the problem interfere with your normal function? _____

Gynecological History (if female)
How many times have you been pregnant? _____ How many times have you given birth? _____
How many of your deliveries were vaginal? _____

Medical Conditions: Please check the appropriate box if you have or have had any of the following

☐ Diabetes	☐ Stroke/TIA	☐ Gall Stones	☐ Osteoporosis
☐ High Blood Pressure	☐ Seizures	☐ Hepatitis	☐ Arthritis
☐ High Cholesterol	☐ Emphysema	☐ Kidney Stones	☐ Multiple Sclerosis
☐ Heart Disease	☐ Asthma	☐ Hypothyroidism	☐ Cancer _____
☐ Heart Attack	☐ Acid Reflux	☐ Glaucoma	☐Blood Clots
☐ Atrial Fibrillation	☐ Ulcers	☐ Gout	☐ Erectile Dysfunction

Prior Surgeries

Procedure:	Date Performed:	Location:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: Please list all of the medications you are currently taking. Include over-the counter medications, herbs, and vitamins.

Medication Name	Dose/Frequency	Last Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: Please list all allergies. State "none" if you do not have any allergies

_____ _____ _____

_____ _____ _____

Height: _____ **Weight: _____**

Please answer the following:

Have you ever smoked cigarettes? ☐ Yes ☐ No If yes, what year did you start? _____

Packs per day _____ If you have stopped, what year did you stop? _____

Do you use chewing tobacco? ☐ Yes ☐ No

Do you drink caffeine? ☐ Yes ☐ No

If yes, how much and what kind (coffee, soda, etc.) _____

How many times in the past year have you had 4 or more drinks containing alcohol in a day? _____

Average drinks per day _____ Did you ever drink heavily in the past? _____

Do you now use, or have you ever used anabolic steroids? ☐ Yes ☐ No

Have you ever had a problem with addiction to prescription pain medication or benzodiazepines (like Valium, Xanax, etc.) ☐ Yes ☐ No

If Yes, please explain. _____

Do you now use, or have you ever used drugs for recreational purposes? ☐ Yes ☐ No

If Yes, check all that apply and give approximate dates used: ☐ Amphetamines _____ ☐ Cocaine _____

☐ Heroine _____ ☐ LSD _____ ☐ Marijuana _____ ☐ Inhalants _____

☐ Other _____

Additional Urologic History

Have you ever had kidney X-Rays (IVP, TC, etc) or Ultrasound? _____

If so, what hospital/facility took the images? _____

Have you ever had a cystoscopic exam (look with a telescope in the bladder)? _____

If so, please indicate results, locations and dates: _____

If male, have you ever had a PSA test (blood test for prostate cancer screening)? _____

If so, what was the result? _____

Do you have urinary leakage? _____

If so, how many protective pads do you use per day? _____

Is your leakage preceded by an urgent sensation to urinate? _____

Is your leakage preceded by coughs, sneezes, laughing or other straining? _____

Do you have a history of bladder cancer and/or prostate cancer? _____

Family Medical History

Please list any diseases or conditions identified in your immediate family (blood relatives).

Disease/Medical Condition	Relation (example: mother, father, son, daughter, etc.)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____