David Collins Horger Urology
Patient Medical History Form

701 Medical Park Dr., Suite 110
Hartsville, SC 29550 843-656-1204

Name:		Referring Physician:		Date:
Birthday:	Age:	Level of Education:	Occupation:	Height:
Marital Status (circle): Married Single Divorced Separated Widowed			Number of Children:	Weight:

1	**Reason for Visit:**	

2	**History of Present Illness:** (Please answer the following questions completely or write N/A)
	Where is your problem located?
	How severe is your problem on a scale of 0 to 10 (10 being most severe)?
	When did you first notice the problem?
	Is the problem constant or variable? (circle) : Dull then Sharp Very sharp then leaves Always there Other:
	Is anything else occurring at the same time? (circle): Yes No (If Yes, please explain)
	Does anything make the problem better?
	Does the problem interfere with your normal functions? (circle): Yes No (If Yes, please explain)

3	**Past Medical Problems**			**List All Other Medical Problems**
	Heart Disease	Yes	No	
	Pacemaker/Defibrillator	Yes	No	
	Lung Disease	Yes	No	
	Diabetes	Yes	No	
	High Blood Pressure	Yes	No	
	Bowel Problems	Yes	No	
	Stroke/Seizures	Yes	No	
	Kidney Problems	Yes	No	
	Bleeding Problems	Yes	No	

4	**Past Surgeries:** or ☐ **NONE**	
	Please List All Surgeries:	Year

5	**Current Medications:** or ☐ **No Medications**	

6	**Allergies:** or ☐ **NONE**			**List All Medication Allergies:**
	Are you allergic to:			
	Latex	Yes	No	
	Shellfish	Yes	No	
	X-Ray Dye	Yes	No	
	Iodine	Yes	No	

7	**Family History**					
	Prostate Cancer	Yes	No	Heart Disease	Yes	No
	Diabetes	Yes	No	Kidney Stones	Yes	No
	Mother's medical problems:					
	Father's medical problems:					
	Other family illnesses:					

8	**Social History**		
	Have you ever smoked?	Yes	No
	If you smoke, how many packs per day?		
	How long ago did you quit smoking?		
	Do you drink alcohol?	Yes	No
	If yes, how much? (circle): rare moderate heavy		
	Have you ever used drugs?	Yes	No

MD Review:	Date: