Loma Linda University Urology Medical Group

Past, Family/Social history form (page 1)

Reason for visit today? ______________________ **Age:** ____________

Referring Doctor's Name: ______________________ **Referring Doctor's FAX:** ____________

Past Medical History

Condition	Yes	No
Measles	Yes	No
Mumps	Yes	No
Neurologic disorders	Yes	No
Meningitis	Yes	No
Tuberculosis (Tb)	Yes	No
Rheumatic fever	Yes	No
Bleeding tendencies	Yes	No
Diabetes	Yes	No
High blood pressures	Yes	No
Gout	Yes	No
Glaucoma	Yes	No
Heart attacks	Yes	No
Heart murmer	Yes	No
Angina (Chest pain)	Yes	No
Emphysema (COPD)	Yes	No
Asthma	Yes	No
Hepatitis or jaundice	Yes	No
Strokes	Yes	No
Thyroid problems	Yes	No
Severe injuries	Yes	No
Psychologic problems	Yes	No
HIV	Yes	No

Other Cancers/Problems: ______________________

____

____

Surgeries

Surgery	Yes	No	Year	Reason
Tonsils	Yes	No	Year ________	Reason ________
Appendix	Yes	No	Year ________	Reason ________
Gall bladder	Yes	No	Year ________	Reason ________
Stomach	Yes	No	Year ________	Reason ________
Breast	Yes	No	Year ________	Reason ________
Uterus	Yes	No	Year ________	Reason ________
Ovary	Yes	No	Year ________	Reason ________
Hernia	Yes	No	Year ________	Side ________
Thyroid	Yes	No	Year ________	Reason ________
Heart	Yes	No	Year ________	Reason ________
Lung	Yes	No	Year ________	Reason ________
Hemorrhoids	Yes	No	Year ________	

Genitourinary Surgeries

Surgery	Yes	No	Year	Reason
Circumcision	Yes	No	Year ________	Reason ________
Vasectomy	Yes	No	Year ________	Reason ________
Penis	Yes	No	Year ________	Reason ________
Prostate	Yes	No	Year ________	Reason ________
Kidney	Yes	No	Year ________	Reason ________
Urinary bladder	Yes	No	Year ________	Reason ________
Testicles	Yes	No	Year ________	Reason ________

Other: ______________________

____

Genitourinary History

Condition	Yes	No
Kidney Stones	Yes	No
Previous Prostate Biopsy	Yes	No
Erectile Dysfunction	Yes	No
Blood in the Urine	Yes	No
Urinary Tract Infections	Yes	No
Prostate Cancer	Yes	No
Kidney Cancer	Yes	No
Bladder Cancer	Yes	No
Testicular Cancer	Yes	No

ALLERGIES (Name of drug and reaction: ☐ **No Known Allergy**

______________ ______________

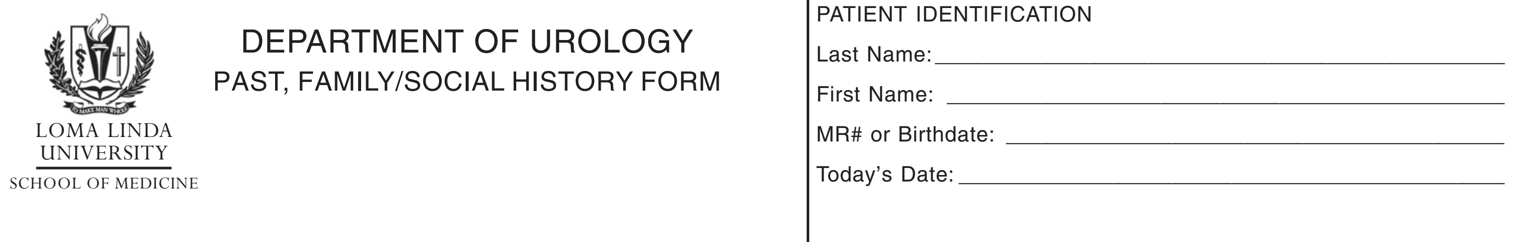
______________ ______________

______________ ______________

______________ ______________

______________ ______________

MEDICATIONS (taken regularly)	Dose	Reason



DEPARTMENT OF UROLOGY

PAST, FAMILY/SOCIAL HISTORY FORM

LOMA LINDA UNIVERSITY

SCHOOL OF MEDICINE

PATIENT IDENTIFICATION

Last Name: ______________________

First Name: ______________________

MR# or Birthdate: ______________________

Today's Date: ______________________

Loma Linda University Urology Medical Group

Past, Family/Social history form (page 2)

Habits/Social History

Tobacco: None ________ Packs per day Year Started: ___________ Year Quit: ___________

Alcohol: None Type: _________________________________ How much? _________________________________

Marital Status: Single Married Divorced Widowed

Occupation ____

Family History

			Relationship
Tuberculosis (Tb)	Yes	No	____________________
Bleeding tendencies	Yes	No	____________________
Diabetes	Yes	No	____________________
High blood pressure	Yes	No	____________________
Strokes	Yes	No	____________________
Heart disease	Yes	No	____________________
Kidney disease/failure	Yes	No	____________________
Severe allergies	Yes	No	____________________

Prostate Cancer	Yes	No	____________________
Kidney Cancer	Yes	No	____________________
Bladder Cancer	Yes	No	____________________
Testis Cancer	Yes	No	____________________
Cervical Cancer	Yes	No	____________________

Other Cancers: ____
____

Other problems: ____
____

Review of systems (Please circle Yes or No)

Constitutional problems:

Fevers/Chills	Yes	No
Fatigue	Yes	No
Marked weight change	Yes	No

Other: ____

Eye problems:

Decreased vision	Yes	No
Double vision	Yes	No
Eye pain	Yes	No

Other: ____

Neurologic problems:

Headaches	Yes	No
Numbness/tingling	Yes	No
Seizures	Yes	No
Fainting spells	Yes	No

Other: ____

Endocrine (Gland) problems:

Excessive thirst	Yes	No
Too hot/cold	Yes	No

Other: ____

GI (Gastrointestinal) problems:

Constipation	Yes	No
Indigestion	Yes	No
Nausea/vomiting	Yes	No
Abdominal pain	Yes	No
Blood in stool	Yes	No
Black, tarry stools	Yes	No
Hemorrhoids	Yes	No

Other: ____

Cardiac (Heart) problems:

Heart attacks	Yes	No
Chest pain/Angina	Yes	No
Palpitations	Yes	No
Ankle swelling	Yes	No
High blood pressure	Yes	No

Other: ____

Skin problems:

Frequent rashes	Yes	No
Boils/infections	Yes	No

Other: ____

Musculoskeletal problems:

Back pain	Yes	No
Neck stiffness/pain	Yes	No
Neck swelling	Yes	No
Joint pain	Yes	No

Other: ____

ENT problems:

Ringing in the ears	Yes	No
Hearing loss	Yes	No
Loss of smell	Yes	No
Nosebleeds	Yes	No
Hoarseness	Yes	No
Dental problems	Yes	No
Sore throats	Yes	No

Other: ____

Pulmonary (Breathing) problems:

Wheezing	Yes	No
Coughing	Yes	No
Shortness of breath	Yes	No
Shortness of breath when lying down	Yes	No
Shortness of breath with exertion	Yes	No
Excess sputum production	Yes	No

How many pillows do you sleep on? ____________________

Other: ____

Heme/Lymph problems:

Blood Transfusions	Yes	No
Clotting problems	Yes	No
Swollen glands	Yes	No

Other: ____

Psych problems:

Depression	Yes	No
Anxiety	Yes	No

Other: ____

Allergies:

Hay fever	Yes	No
Drug Allergies	Yes	No

Other: ____

Breast (if appropriate):

Discharge	Yes	No
Lumps	Yes	No
Pain	Yes	No

Other: ____

GYN (if appropriate):

Vaginal discharge	Yes	No

Last menstrual period ____________________

Last PAP smear ____________________

Age when menstrual periods began ____________________

Interval between menstrual periods ____________________

Pregnancies ____________________

Births ____________________

____

Physician's Signature Date

Duane Baldwin, M.D.
Gary Barker, M.D.
H. Roger Hadley, M.D.
Noel Hui, M.D.
Paul Lui, M.D.
Herbert Ruckle, M.D.
Kristin Sanderson, M.D. M.P.H.
Steven Stewart, M.D.
Shannon Oien, N.P.
Karen Uyemura, N.P.