DEPARTMENT OF UROLOGY
MOUNT SINAI SCHOOL OF MEDICINE

Patient and Family History-Page 1

Date: _____

Name: _____ Date of Birth: _____ Age : _____ Sex: (M/F)

Reason for Today's Visit: Initial Visit: _____ Consultation: _____ Requested By_____

History of Present Illness:

Reason for being seen today_____

What symptoms do you have? _____

How long have the symptoms been present? _____

What tests have been done, if any? _____

What treatments and/or medications have been given? _____
_____

Medical History:

(Circle all that apply)

Alcoholism	Glaucoma	High Cholesterol	Thyroid disease
Anemia	Gout	Kidney disease	HIV/AIDS
Bleeding disorders	Heart disease	Liver disease	Ulcers
Bronchitis/Emphysema	Hepatitis	Pacemaker	Other: _____
Cancer	Herpes	Sickle cell	_____
Diabetes	High Blood Pressure	TB	

Do you have Allergies (Y/N) _____ If Yes please list _____
_____

Type of allergic reaction: _____

Are you on any Medications (Y/N) _____ if yes please list _____
_____ **Pharmacy Number _____**

List any serious illness, hospitalizations, or surgeries you have had, with dates: _____
_____

List History of Kidney/Urological Problems: _____
_____

Social History:

Marital Status: Single Divorced Married Widow/Widower

Employment/Student Status: _____ Occupation: _____

Do you smoke? _____ How many pack a day? _____ For how many years? _____

Do you drink alcohol? _____ How many drinks per day? _____ Per week? _____ Per month? _____

Are you sexually active? _____ Do you use illicit drugs? _____ If yes, what kind? _____

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Family History:

What is the Health Status of your Family?

Mother: _____ Father: _____

Brother/Sisters: _____

Family Illness:

Do any of the following illnesses exist in your family? "Yes" or "No"

T/B Cystic Fibrosis _____ Seizures _____ Anemia, Bleeding _____ Diabetes _____

Kidney Problems _____ Arthritis _____ High Blood Pressure _____ Cancer _____

Heart Problems _____ Asthma _____ Gastrointestinal Disease _____ Birth Defects _____

Family History of Kidney/Urological Problems: _____

_____

Patient Signature: _____ Date: _____

Physician use Only: **(Comments/Notes)**

I have reviewed the History as documented in the Medical History Questionnaire

_____ _____

Signature of Provider Date