

**UROLOGY ASSOCIATES, S.C.**  
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**PATIENT HISTORY FORM**

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_  
What is the main reason for your visit today? (Describe your problem in detail.)

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**History of Present Illness**

Please answer the following questions:

Location of the problem: Abdomen      Back      Leg      Other: \_\_\_\_\_

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem.

1      2      3      4      5      6      7      8      9      10

When did you first notice the problem?      2 days ago      1 month ago      Other: \_\_\_\_\_

Does anything help or make the problem worse?      Moving around      Standing up      Lying on my side  
Other: \_\_\_\_\_

How long does the problem last?      30 minutes      1 hour      It is always there      Other: \_\_\_\_\_

Is anything else occurring at the same time?      Yes      No  
If yes, please explain:      Nausea      Rash      Headaches      Other: \_\_\_\_\_

Is the problem constant or variable?  
Dull then sharp?      Very sharp then leaves?      Always there?      Other: \_\_\_\_\_

Does the problem interfere with your normal functions?      Yes      No

**Past Medical & Social History**

List all serious illnesses in your immediate family. (Example: Diabetes, tuberculosis, breast cancer, heart disease, etc.) If parents deceased, age at death and cause, if known.

_____	_____	_____
_____	_____	_____
_____	_____	_____

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery	Date	Illness or Surgery	Date	Illness or Surgery	Date
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Do you smoke?**      Yes      No      If yes, how much/how long? \_\_\_\_\_  
**Do you drink alcohol?**      Yes      No      If yes, how much/how long? \_\_\_\_\_

# Review of Systems

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Do you now or have you had any problems related to the following systems? Circle Yes or No

## Constitutional Symptoms

Fever Y N  
Chills Y N  
Headache Y N  
Other: \_\_\_\_\_

## Eyes

Blurred Vision Y N  
Pain Y N  
Double vision Y N  
Other: \_\_\_\_\_

## Ears/Nose/Throat/Mouth

Ear Infection Y N  
Sore Throat Y N  
Sinus problems Y N  
Other: \_\_\_\_\_

## Respiratory

Wheezing Y N  
Frequent Cough Y N  
Short of breath Y N  
Other: \_\_\_\_\_

## Gastrointestinal

Abdominal Pain Y N  
Nausea/Vomiting Y N  
Indigestion/Heartburn Y N  
Other: \_\_\_\_\_

## Genitourinary

Urine Retention Y N  
Painful Urination Y N  
Urinary frequency Y N  
Other: \_\_\_\_\_

## Musculoskeletal

Joint Pain Y N  
Neck Pain Y N  
Back pain Y N  
Other: \_\_\_\_\_

## Psychologic

Are you generally satisfied with your life? Y N  
Do you feel severely depressed? Y N  
Have you considered suicide? Y N  
Other: \_\_\_\_\_

## Integumentary

Skin Rash Y N  
Persistent Itching Y N  
Boils Y N  
Other: \_\_\_\_\_

## Neurological

Tremors Y N  
Dizzy spells Y N  
Numbness/tingling Y N  
Other: \_\_\_\_\_

## Endocrine

Excessive Thirst Y N  
Too hot/cold Y N  
Tired/sluggish Y N  
Other: \_\_\_\_\_

## Cardiovascular

Chest pain Y N  
High Blood Pressure Y N  
Varicose veins Y N  
Other: \_\_\_\_\_

## Hematologic/Lymphatic

Swollen glands Y N  
Anemia Y N  
Blood clotting problems Y N  
Other: \_\_\_\_\_

## Allergic/Immunologic

Hay fever Y N  
Drug allergies Y N  
Other: \_\_\_\_\_

Please explain any "yes" answers here.

Physician Use Only: Comments/Notes