SPRINGS UROLOGY
1725 University Drive, Suite 400 • Coral Springs, Florida 33071
Office 954.752.3166 • Fax 954.753.5628

DAWN SCARZELLA, M.D.
OMAR ORTIZ-ALVARADO, M.D.
AARON BRAFMAN, M.D.

PATIENT HISTORY FORM

DATE: ____________________

NAME: ____________________ DATE OF BIRTH: ____________________

PHONE NUMBER: ____________________ SECONDARY PHONE NUMBER: ____________________

EMAIL:

REASONS FOR TODAY'S VISIT: ____________________

PRIMARY DOCTOR & PHONE #: ____________________ REFERRING DOCTOR: ____________________

PHARMACY NAME & PHONE #: ____________________

PAST MEDICAL HISTORY

- ☐ ALZHEIMER'S DISEASE
- ☐ ANEMIA
- ☐ ANXIETY DISORDER
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BLEEDING DISORDERS
- ☐ CARDIAC ARRHYTHMIA
- ☐ CONGESTIVE HEART DISEASE
- ☐ COPD (LUNG DISEASE)
- ☐ CORONARY HEART DISEASE
- ☐ DEPRESSION
- ☐ DIABETES MELLITUS
- ☐ DVT (VENOUS EMBOLISM)
- ☐ ELEVATED CHOLESTEROL
- ☐ ESOPHAGEAL REFLUX
- ☐ FIBROMYALGIA
- ☐ GLAUCOMA (OPEN/CLOSED)
- ☐ HEART ATTACK (MI)
- ☐ HEPATITIS
- ☐ HERNIA
- ☐ HYPERTENSION
- ☐ HYPERTHYROIDISM
- ☐ HYPOTHYROIDISM
- ☐ IRRITABLE BOWEL DZ
- ☐ KIDNEY STONE
- ☐ MIGRAINE / HEADACHE
- ☐ OSTEOPOROSIS
- ☐ SEIZURE
- ☐ STROKE (CVA)
- ☐ TRANSIENT ISCHEMIC ATTACK

☐ CANCER (LIST ALL): ____________________

PAST SURGICAL HISTORY

- ☐ APPENDECTOMY
- ☐ BACK SURGERY
- ☐ C-SECTION
- ☐ CABG (CORONARY BYPASS)
- ☐ CATARACTS
- ☐ CHOLECYSTECTOMY
- ☐ COLON RESECTION
- ☐ COLONOSCOPY
- ☐ GASTRIC BYPASS
- ☐ HEMORRHOIDECTOMY
- ☐ HERNIA REPAIR
- ☐ HIP REPLACEMENT
- ☐ HYSTERECTOMY
- ☐ KNEE SURGERY
- ☐ LASIK (EYE CORRECTION)
- ☐ NEPHRECTOMY
- ☐ PACEMAKER IMPLANT
- ☐ PROSTATECTOMY
- ☐ SHOULDER SURGERY
- ☐ SPLENECTOMY
- ☐ THYROIDECTOMY
- ☐ TONSILLECTOMY
- ☐ TURP
- ☐ VASECTOMY

DRUG ALLERGIES

☐ NONE

DRUG	REACTION

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MEDICATION HISTORY
LIST ALL INCLUDING OVER THE COUNTER ◻ NONE

NAME OF DRUG	DOSE	# TIMES PER DAY	NAME OF DRUG	DOSE	# TIMES PER DAY
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______

ARE YOU TAKING ANY BLOOD THINNERS? (CHECK ALL THAT APPLY) ◻ YES ◻ NO

◻ ASPIRIN ◻ COUMADIN ◻ WARFARIN ◻ ELIQUIS ◻ XARELTO ◻ PRADAXA ◻ PLAVIX ◻ AGGRENOX ◻ BRILINTA

◻ OTHER____

FAMILY HISTORY
(PLEASE SPECIFY FAMILY MEMBER)

BLADDER CANCER	◻ YES	◻ NO	______	DIABETES	◻ YES	◻ NO	______
BREAST CANCER	◻ YES	◻ NO	______	HEART DISEASE	◻ YES	◻ NO	______
CERVICAL CANCER	◻ YES	◻ NO	______	HYPERTENSION	◻ YES	◻ NO	______
KIDNEY CANCER	◻ YES	◻ NO	______	KIDNEY STONES	◻ YES	◻ NO	______
OVARIAN CANCER	◻ YES	◻ NO	______	OTHER	◻ YES	◻ NO	______
PROSTATE CANCER	◻ YES	◻ NO	______	OTHER	◻ YES	◻ NO	______
UTERINE CANCER	◻ YES	◻ NO	______	OTHER	◻ YES	◻ NO	______

			DATE
DID YOU GET A FLU SHOT THIS YEAR?	◻ YES	◻ NO	______
DID YOU GET A PNEUMOCOCCAL VACCINE?	◻ YES	◻ NO	______
ADMINISTERED BY______________________			
HAVE YOU RECENTLY BEEN TESTED FOR COVID?	◻ YES	◻ NO	______
HAVE YOU RECEIVED THE 2ND COVID VACCINE?	◻ YES	◻ NO	______

SOCIAL HISTORY

MARITAL STATUS: ◻ SINGLE ◻ MARRIED ◻ DIVORCED

TOBACCO USE: ◻ NON SMOKER ◻ SMOKER ____ PACKS/DAY ___ YEARS ◻ PREVIOUS SMOKER – QUIT __________

ALCOHOL USE: ◻ NON DRINKER ◻ SOCIAL ◻ DRINKER ___ DRINKS/DAY

HOW MANY CAFFEINATED DRINKS PER DAY? 0 1 2 3 4 5+

HEIGHT: _______ FEET _______ INCHES WEIGHT: _________ LBS.

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CONSTITUTIONAL

FEVER	☐ YES	☐ NO
CHILLS	☐ YES	☐ NO
HOT FLASHES	☐ YES	☐ NO
FATIGUE	☐ YES	☐ NO
WEIGHT LOSS	☐ YES	☐ NO
WEIGHT GAIN	☐ YES	☐ NO
WEAKNESS	☐ YES	☐ NO
LOSS OF APPETITE	☐ YES	☐ NO

OPHTHALMOLOGY

CATARACTS	☐ YES	☐ NO
GLAUCOMA	☐ YES	☐ NO
BLURRY VISION	☐ YES	☐ NO
DRY EYES	☐ YES	☐ NO
VISION LOSS	☐ YES	☐ NO

ENT

TINNITIS (RINGING IN EAR)	☐ YES	☐ NO
HEARING LOSS / DIFFICULTY HEARING	☐ YES	☐ NO
SINUS PROBLEMS	☐ YES	☐ NO
NOSE BLEEDS	☐ YES	☐ NO
DRY MOUTH	☐ YES	☐ NO
DIFFICULTY SWALLOWING	☐ YES	☐ NO
SORE THROAT	☐ YES	☐ NO

CARDIOLOGY

SWELLING OF ANKLES	☐ YES	☐ NO
CHEST PAIN	☐ YES	☐ NO
DIZZINESS	☐ YES	☐ NO
IRREGULAR HEARTBEAT	☐ YES	☐ NO
PALPITATIONS	☐ YES	☐ NO

RESPIRATORY

SHORTNESS OF BREATH	☐ YES	☐ NO
WHEEZING	☐ YES	☐ NO
COUGH	☐ YES	☐ NO

GASTROENTEROLOGY

ABDOMINAL PAIN	☐ YES	☐ NO
CONSTIPATION	☐ YES	☐ NO
DIARRHEA	☐ YES	☐ NO
NAUSEA / VOMITING	☐ YES	☐ NO
HEARTBURN / INDIGESTION	☐ YES	☐ NO
BLOOD IN STOOL	☐ YES	☐ NO

MUSCULOSKELETAL

FLANK PAIN	☐ YES	☐ NO
BACK PAIN	☐ YES	☐ NO
SORE MUSCLES	☐ YES	☐ NO
JOINT SWELLING, STIFFNESS, PAIN	☐ YES	☐ NO

UROLOGIC

NIGHTTIME URINATION	☐ YES	☐ NO
DIFFICULTY STARTING STREAM	☐ YES	☐ NO
WEAK STREAM	☐ YES	☐ NO
LEAKAGE OR DRIBBLING	☐ YES	☐ NO
PAINFUL URINATION	☐ YES	☐ NO
BLOOD IN URINE	☐ YES	☐ NO
FREQUENT URINATION	☐ YES	☐ NO
URGENT URINATION	☐ YES	☐ NO
INCOMPLETE BLADDER EMPTYING	☐ YES	☐ NO

GYNECOLOGIC

POST MENOPAUSAL	☐ YES	☐ NO
CURRENTLY ON HORMONE REPLACEMENT?	☐ YES	☐ NO
VAGINAL DRYNESS	☐ YES	☐ NO
VAGINAL PAIN	☐ YES	☐ NO
VAGINAL DISCHARGE	☐ YES	☐ NO
VAGINAL ITCHING	☐ YES	☐ NO
PAIN WITH SEX	☐ YES	☐ NO

MALE REPRODUCTIVE

DIFFICULTY WITH ERECTION	☐ YES	☐ NO
PAIN WITH ERECTION	☐ YES	☐ NO
DIFFICULTY WITH EJACULATION	☐ YES	☐ NO
DIMINISHED SEXUAL DRIVE	☐ YES	☐ NO
PENILE PAIN	☐ YES	☐ NO
PENILE CURVATURE	☐ YES	☐ NO
TESTICULAR PAIN	☐ YES	☐ NO

ENDOCRINE

EXCESSIVE THIRST	☐ YES	☐ NO
EXCESSIVE URINATION	☐ YES	☐ NO
COLD INTOLERANCE	☐ YES	☐ NO
HEAT INTOLERANCE	☐ YES	☐ NO

HEMATOLOGIC / LYMPHATIC

BRUISES EASILY	☐ YES	☐ NO
SWOLLEN LYMPH NODES	☐ YES	☐ NO
BLOOD CLOTTING PROBLEM	☐ YES	☐ NO

DERMATOLOGY

RASH	☐ YES	☐ NO
ITCHING	☐ YES	☐ NO
DRY OR SENSITIVE SKIN	☐ YES	☐ NO
SKIN CANCER	☐ YES	☐ NO

NEUROLOGY

HEADACHE	☐ YES	☐ NO
NUMBNESS / TINGLING	☐ YES	☐ NO
WEAKNESS	☐ YES	☐ NO
DIZZINESS	☐ YES	☐ NO
SEIZURES / CONVULSIONS	☐ YES	☐ NO
ANXIETY / DEPRESSION	☐ YES	☐ NO