

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 #: _____

DRUG ALLERGIES

NONE

DRUG

REACTION

MEDICATION 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 _____

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 _____

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.

PAST SURGICAL HISTORY

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> APPENDECTOMY | <input type="checkbox"/> COLON RESECTION | <input type="checkbox"/> HYSTERECTOMY | <input type="checkbox"/> SHOULDER SURGERY |
| <input type="checkbox"/> BACK SURGERY | <input type="checkbox"/> COLONOSCOPY (DATE: _____) | <input type="checkbox"/> KNEE SURGERY | <input type="checkbox"/> SPLENECTOMY |
| <input type="checkbox"/> C-SECTION | <input type="checkbox"/> GASTRIC BYPASS | <input type="checkbox"/> LASIK (EYE CORRECTION) | <input type="checkbox"/> THYROIDECTOMY |
| <input type="checkbox"/> CABG (CORONARY BYPASS) | <input type="checkbox"/> HEMORRHOIDECTOMY | <input type="checkbox"/> NEPHRECTOMY | <input type="checkbox"/> TONSILLECTOMY |
| <input type="checkbox"/> CATARACTS | <input type="checkbox"/> HERNIA REPAIR | <input type="checkbox"/> PACEMAKER IMPLANT | <input type="checkbox"/> TURP |
| <input type="checkbox"/> CHOLECYSTECTOMY | <input type="checkbox"/> HIP REPLACEMENT | <input type="checkbox"/> PROSTATECTOMY | <input type="checkbox"/> VASECTOMY |

PAST MEDICAL HISTORY

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

FAMILY HISTORY (PLEASE SPECIFY FAMILY MEMBER)

- | | | | | | | | |
|-----------------|------------------------------|-----------------------------|-------|---------------|------------------------------|-----------------------------|-------|
| BLADDER CANCER | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ | DIABETES | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| BREAST CANCER | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ | HEART DISEASE | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| CERVICAL CANCER | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ | HYPERTENSION | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| KIDNEY CANCER | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ | KIDNEY STONES | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| OVARIAN CANCER | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ | OTHER | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| PROSTATE CANCER | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ | OTHER | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| UTERINE CANCER | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ | OTHER | <input type="checkbox"/> YES | <input type="checkbox"/> 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.

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.

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