UW Medicine
KIDNEY STONE CENTER

# Health History Form

Patient Label

**DATE:** _____

**NAME: Last** _____ **First** _____ **MI**_____**Gender:** ☐ **M** ☐ **F Birthdate:** _____

**Referring Provider**: _____ **Have you seen a urologist?** ☐ **Y** ☐ **N Reason:**_____

**REASON FOR TODAY'S VISIT**: _____

| **Allergies:** | **Medication or Substance** | **Reaction** |
|---|---|---|
| ☐ No Allergies | | |
| | | |
| | | |

| **Current Medicine:** | **Label – Name** | **Dose** | **Frequency** |
|---|---|---|---|
| OR | | | |
| ☐ See attached list | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Social History

☐ Single ☐ Married (their name: _____) ☐ Other Partner Name: _____ # Kids _____

Do you use tobacco products? ☐ Daily ☐ Some Days ☐ Quit ☐ Passive (around cigarette smoke) ☐ Never
Packs per Day _____ Years Smoked _____ Date Quit _____
Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Chew ☐ Snuff

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit Date Quit _____
Drinks per Day _____ Drinks per Week _____ Type: ☐ Beer ☐ Wine ☐ Liquor

Do you use recreational drugs? ☐ Never ☐ Yes – Use per Week _____ ☐ No ☐ Quit Date Quit _____
Have you ever used injected/IV drugs: ☐ Yes ☐ No
Types: ☐ Cocaine ☐ Marijuana ☐ Methamphetamines ☐ Stimulants ☐ Heroin
☐ Depressants ☐Hallucinogens (LSD, mushrooms) ☐ Opioids (vicodin, oxycodone)

Are you sexually active? ☐ Yes ☐ No Partners: ☐ Male ☐ Female ☐ Both Birth Control: _____

Are you working? ☐ Yes What do you do? _____ ☐ No ☐ Retired ☐ Disabled

## Kidney Stone Medical History

**Please check box for those conditions you have now or have ever had**

Have you had genital reconstruction? ☐ Yes ☐ No
Have you had a UTI? ☐ Yes ☐ No If so date of last UTI_____
Number of UTI per year_____
Have you have Kidney Stones before? ☐ Yes ☐ No ☐ Unsure
Is this your first Kidney Stone? ☐ Yes ☐ No ☐ Unsure
Do you have a history of Kidney Stones? ☐ Yes ☐ No ☐ Unsure
Have you passed any Kidney Stones this episode? ☐ Yes ☐ No If so, when? _____

What type of kidney stone did you have? ☐ Calcium Oxalate ☐ Calcium Phosphate ☐ Uric Acid ☐ Cystine ☐ Struvite
☐ Other_____

What prevention measures have you tried?

| Prevention Measure | When | Results (e.g., did it help?) |
|---|---|---|
| | | |
| | | |
| | | |

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## Kidney Stone Medical History (Continued)

**Please check box for those conditions you have now or have ever had**

Are you experiencing any pain? ☐ Yes ☐ No

If so, where is your pain? (Select all that apply.) ☐ Right Flank ☐ Left Flank ☐ Right Pelvis ☐ Left Pelvis ☐ Abdomen ☐ Middle Back ☐ Genitalia

On a scale of 1 to 10, how bad is your pain? (Please circle one)


What measures are you taking to manage your pain? _____

_____

_____

## Medical History (Continued)

**Please check box for those conditions you have now or have ever had**

- ☐ No Past Medical History
- ☐ Atrial Fibrillation
- ☐ Bipolar
- ☐ Bladder Cancer
- ☐ Bladder Pain/Interstitial Cystitis
- ☐ Bladder Stone
- ☐ Colon Cancer
- ☐ Constipation
- ☐ Coronary Artery Disease
- ☐ Ejaculatory Dysfunction
- ☐ Enuresis/Bed Wetting
- ☐ Erectile Dysfunction
- ☐ Exstrophy
- ☐ Fecal Incontinence
- ☐ Fibroids
- ☐ Fibromyalgia
- ☐ Gout
- ☐ History of Irradiation
- ☐ Hormone Problems
- ☐ Hypogonadism
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Cancer
- ☐ Kidney Cyst
- ☐ Kidney Stones
- ☐ Kidney Trauma
- ☐ Menopause
- ☐ Neurogenic Bladder
- ☐ Obesity
- ☐ Ovarian Cancer
- ☐ Polcystic Kidney
- ☐ Pyelonephritis/Kidney Infection
- ☐ Sexual Abuse
- ☐ Spinal Cord Injury
- ☐ STI (Sexual Transmitted Infection)
- ☐ Upper Tract Urothelial Cancer
- ☐ Ureter Stones
- ☐ Ureteral Cancer
- ☐ Urethral Stricture
- ☐ Urge Incontinence
- ☐ Urinary Incontinence, Stress
- ☐ Urinary Retention
- ☐ Urinary Tract Infection
- ☐ Uterine Cancer
- ☐ Vaginal Infection

- ☐ Allergic Rhinitis
- ☐ Anemia
- ☐ Anesthesia Problems
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding/Clotting Disorder
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Atherosclerosis
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Gastric Ulcer
- ☐ GERD
- ☐ Glaucoma
- ☐ GYN
- ☐ Headache
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV
- ☐ Hypertension
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Lipid/Cholesterol
- ☐ Lung Disease
- ☐ Musculoskeletal
- ☐ Myocardial Infarction
- ☐ Osteoporosis
- ☐ PPD
- ☐ Seizures
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tuberculosis

## Surgical History

**Please check box for those conditions you have now or have ever had**

- ☐ No Past Surgical History
- ☐ Extracorporeal Shock Wave Lithotripsy Right (_____)
- ☐ Percutaneous Nephrolithotomy Right (_____)
- ☐ Utereroscopy Right (_____)
- ☐ Radical Prostatectomy (___)
- ☐ Extracorporeal Shock Wave Lithotripsy Left (_____)
- ☐ Percutaneous Nephrolithotomy Left (_____)
- ☐ Utereroscopy Left (_____)

☐ Other (Please list urologic procedures):

_____

_____

_____

Complications from Anesthesia ☐ No ☐ Yes Please explain.

_____

_____

_____

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## Family History–Check all that apply

| Relationship | First Name | Status (circle) | No Known Problems | Bladder Cancer | Colon Cancer | Early Sudden Death | Heart Attack | Heart Disease | Hypertension | incontinence | Kidney Cancer | Kidney Stones | Renal Syndrome | Prostate Cancer | Testis Cancer | Undescended Testicle | Urinary Tract Infection | Other: ____ | Other: ____ | Other: ____ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | alive deceased | | | | | | | | | | | | | | | | | | |
| Father | | alive deceased | | | | | | | | | | | | | | | | | | |
| Sister | | alive deceased | | | | | | | | | | | | | | | | | | |
| Brother | | alive deceased | | | | | | | | | | | | | | | | | | |
| Maternal Grandmother | | alive deceased | | | | | | | | | | | | | | | | | | |
| Maternal Grandfather | | alive deceased | | | | | | | | | | | | | | | | | | |
| Paternal Grandmother | | alive deceased | | | | | | | | | | | | | | | | | | |
| Paternal Grandfather | | alive deceased | | | | | | | | | | | | | | | | | | |

## Screening

In the past two weeks, how often have you been bothered by the following? (Please circle one response per statement.)

| | | | | |
|---|---|---|---|---|
| Little interest or pleasure in doing things | Not at all | Several days | More than half the days | Nearly every day |
| Feeling down, depressed, or hopeless | Not at all | Several days | More than half the days | Nearly every day |

Have you fallen in the past year? ☐ Yes ☐ No
Are you afraid of falling? ☐ Yes ☐ No
Do you have issues with balance or feeling unsteady? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No

## Review of Systems (current symptoms) – please check only if these are bothering you at this time

| System | Symptom | Comments |
|---|---|---|
| Genitourinary | ☐ Sexual Problems<br>☐ Blood in Urine<br>☐ Burning with Urination<br>☐ Leakage of Urine<br>☐ Urgency of Urination<br>☐ Frequency of Urination<br>☐ Urinary Tract Infection | |
| Gastrointestinal | ☐ Poor Appetite<br>☐ Stomach Pain<br>☐ Diarrhea<br>☐ Constipation<br>☐ Abdominal Swelling<br>☐ Vomiting<br>☐ Vomiting Blood<br>☐ Nausea<br>☐ Trouble Swallowing<br>☐ Heartburn/ Indigestion<br>☐ Black Tarry Stools<br>☐ Rectal Bleeding<br>☐ Other | |
| Constitutional | ☐ Fevers<br>☐ Chills<br>☐ Weight Gain/ Loss<br>☐ Fatigue | |

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**Review of Systems (current symptoms) – please check only if these are bothering you at this time**

| System | Symptom | Comments |
|---|---|---|
| Heart | ☐ Chest Pain<br>☐ Palpitations<br>☐ Irregular Heart Beat<br>☐ High Blood Pressure | |
| Endocrine | ☐ Hot Flashes<br>☐ High Thirst<br>☐ Bothered by Cold<br>☐ Bothered by Heat | |
| Head/ Eyes | ☐ Cataracts<br>☐ Poor Vision<br>☐ Dry Eyes<br>☐ Color Blindness | |
| Ear/ Nose/ Mouth/ Throat | ☐ Hearing Loss<br>☐ Heavy Snoring<br>☐ Chronic Sinus Congestion<br>☐ Bad Teeth | |
| Vascular | ☐ Blood Clots<br>☐ Varicose Veins | |
| Blood/ Lymph | ☐ Swollen Lymph Nodes<br>☐ Easy Bruising<br>☐ Easy Bleeding | |
| Respiratory | ☐ Cough<br>☐ Shortness of Breath<br>☐ Asthma<br>☐ Emphysema (COPD) | |
| Skin | ☐ Rash<br>☐ Itching<br>☐ Jaundice<br>☐ Psoriasis | |
| Muscles/ Bones | ☐ Chronic Pain<br>☐ Muscle Weakness<br>☐ Arthritis<br>☐ Muscle Cramping<br>☐ Bone Pain<br>☐ Joint Pain | |
| Neurological | ☐ Headaches<br>☐ Confusion<br>☐ Seizures (Epilepsy)<br>☐ Tremor (Shaking) | |
| Psychosocial | ☐ Anxiety/ Nerves<br>☐ Depression<br>☐ Abusive Relationship<br>☐ Feeling Worthless<br>☐ Sexual Problems<br>☐ Want to Hurt Yourself<br>☐ Sleep Problems<br>☐ Want to Hurt Others<br>☐ Alcohol Use<br>☐ Drug Use | |