Patient Name _____

Primary Care Doctor _____

Referring Doctor _____

Medication List

Name	Dose	Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacy Name: _____

Phone Number:_____

Secondary Pharmacy Name: _____

Phone Number: _____

Allergies:_____

_____

_____

_____

OFFICE USE ONLY: WT- _____ **BP-**_____ **P -** _____ **HT -** _____

Past Medical History

____ Arthritis	____ Asthma	____ Congestive Heart Failure
____ COPD	____ Depression	____ Diabetes
____ Glaucoma	____ Heart Attack	____ Hepatitis
____ High Cholesterol	____ High Blood Pressure	____ Kidney Stones
____ Seizures	____ Stroke	

____ Cancer (Type) _____

____ Other_____

Please list any Surgeries from Birth to Present:

Surgery	Date

Patient Name_____

Family History

Prostate Cancer

□ Father □ Brother

Urinary Tract Infections

□ Mother □ Father □ Brother □ Sister

Cancer (Type) _____

□ Mother □ Father □ Brother □ Sister

High Blood Pressure

□ Mother □ Father □ Brother □ Sister

Kidney Stones

□ Mother □ Father □ Brother □ Sister

Renal Failure

□ Mother □ Father □ Brother □ Sister

Diabetes

□ Mother □ Father □ Brother □ Sister

Coronary Artery Disease

□ Mother □ Father □ Brother □ Sister

Other _____

Social History

_____ **Single** _____ **Married** _____ **Divorced** _____**Widowed** _____ **Separated**

Do You Smoke: _____ Yes _____ No _____ Previously

When did you start: _____ **Packs per day:** _____

When did you quit: _____

Any Alcohol Use: _____ Yes _____ No _____ Previously

How many drinks per: _____ Day _____ Week _____ Month _____ Year (choose one)

Type of Alcohol: _____ Beer _____ Liquor _____ Wine

_____ Social _____ Light _____ Moderate _____ Excessive

When did you quit: _____ **How long did you drink**:_____

How many caffeinated drinks per day: _____

Have you had a blood transfusion: _____ **Yes** _____ **No**

Patient Name _____

Have you ever see a urologist before? Yes No Please Circle)

If yes – Who did you see ? _____

When? _____

For what reason were you seeing a urologist? _____

_____

Please list any other specialists you have seen:

Name **Phone number**

_____

_____

_____

_____

Please Check All That Apply to You

General Health/Constitutional

_____ Fever

_____ Weight loss

_____ Fatigue

Eyes

_____ Blurry Vision

_____ Double Vision

_____ Cataracts

Ears, Nose, Mouth and Throat

_____ Hearing Loss

_____ Nasal Stuffiness

_____ Sore Throat

Cardiovascular

_____ Chest Pain

_____ Swollen Ankles

_____ Irregular Heartbeat

Respiratory

_____ Shortness of Breath

_____ Wheezing

_____ Chronic Cough

Gastrointestinal

_____ Abdominal Pain

_____ Nausea/Vomiting

_____ Change in Bowels

Genitourinary

_____ Incontinence

_____ Painful Urination

_____ Blood in Urine

Musculoskeletal

_____ Chronic Back Pain

_____ Chronic Neck Pain

_____ Sore Muscles

Integumentary

_____ Rash

_____ Persistent Itching

_____ Genital Sores

Neurological

_____ Numbness

_____ Tingling

_____ Dizziness

Hematologic/Lymphatic

_____ Swollen Glands

_____ Abnormal Bleeding

_____ Blood Clots