

Please fill out both sides of this form completely

Urologist: _____ Account: _____ Date: _____

Name: _____ Date of Birth: _____

The Name of your Primary Care Physician: _____

Name the Physician that referred you if different: _____

**List the names of all the medicines you take including any supplements or over-the-counter drugs:
Dosage is not needed**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- Are you Allergic to:** No Drug Allergies
- | | | | | | | |
|---------------------------------------|--------------------------------------|----------------------------------|-----------------------------------|---------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Demerol | <input type="checkbox"/> IVP Dye | <input type="checkbox"/> Levaquin | <input type="checkbox"/> Macrochantin | <input type="checkbox"/> Percocet | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Cipro | <input type="checkbox"/> Erthromycin | <input type="checkbox"/> Keflex | <input type="checkbox"/> Lortab | <input type="checkbox"/> Morphine | <input type="checkbox"/> Phenergan | <input type="checkbox"/> X Ray Dye |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex | <input type="checkbox"/> Macrobid | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Seafood | |
| <input type="checkbox"/> Other: _____ | | | | | | |

Your Medical History - Please Check if you have or ever have any of the following diseases:

- | | | |
|---|---|--|
| <input type="checkbox"/> Acid Reflux (GERD) | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Prior Radiation Treatment |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Spastic Colon |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Irregular Heartbeats | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease / Emphysema | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Prior Chemotherapy | <input type="checkbox"/> Other _____ |

Your Surgical History - Please check if you have had any of the following Surgeries:

- | | | |
|---|---|---|
| <input type="checkbox"/> Abdominal Aneurysm | <input type="checkbox"/> Cervical Disc | <input type="checkbox"/> Ovary |
| <input type="checkbox"/> Abdominal Hernia | <input type="checkbox"/> Colon | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Abdominal Hysterectomy | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Splenectomy |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Heart By Pass | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Heart Valve | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Hernia (Left) | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Hernia (Right) | <input type="checkbox"/> Vaginal Hysterectomy |
| <input type="checkbox"/> C - Section | <input type="checkbox"/> Joint Surgery | <input type="checkbox"/> None |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Kidney Stone Surgery | |

Your Family History - Please check if your Mother, Father, Brother or Sister ever had any of the following diseases:

- | | | |
|--|--|--|
| <input type="checkbox"/> Family History: Bladder Cancer | <input type="checkbox"/> Family History: Kidney Cancer | <input type="checkbox"/> Family History: Diabetes |
| <input type="checkbox"/> Family History: Kidney Disease | <input type="checkbox"/> Family History: Heart Disease | <input type="checkbox"/> Family History: Prostate Cancer |
| <input type="checkbox"/> Family History: High Blood Pressure | | |

Your Social History:

- | | | | | |
|-----------------------------------|----------|--|---------------------------------|--------------|
| <input type="checkbox"/> Divorced | Tobacco? | <input type="checkbox"/> Current - Everyday | <input type="checkbox"/> Former | Amount _____ |
| <input type="checkbox"/> Married | | <input type="checkbox"/> Current - Some Days | <input type="checkbox"/> Never | |
| <input type="checkbox"/> Single | | | | |
| <input type="checkbox"/> Widowed | Alcohol? | <input type="checkbox"/> Current - Everyday | <input type="checkbox"/> Former | Amount _____ |
| | | <input type="checkbox"/> Current - Some Days | <input type="checkbox"/> Never | |

Do you have the following symptoms or diseases?

Fever	Yes _____	No _____	Rash	Yes _____	No _____
Chills	Yes _____	No _____	New Skin Lesions	Yes _____	No _____
Double Vision	Yes _____	No _____	Memory Difficulties	Yes _____	No _____
Cataracts	Yes _____	No _____	Headaches	Yes _____	No _____
Hearing Loss	Yes _____	No _____	Mini Strokes	Yes _____	No _____
Headaches	Yes _____	No _____	Seizures	Yes _____	No _____
Chest Pain at Rest	Yes _____	No _____	Muscle Weakness	Yes _____	No _____
Chest Pain with Exercise	Yes _____	No _____	Joint Pain	Yes _____	No _____
Irregular Heart Beats	Yes _____	No _____	Hot Flashes	Yes _____	No _____
Palpitations	Yes _____	No _____	Thyroid Disorder	Yes _____	No _____
Leg Cramps with Exercise	Yes _____	No _____	Depression	Yes _____	No _____
Shortness of Breath	Yes _____	No _____	Schizophrenia	Yes _____	No _____
Wheezing	Yes _____	No _____	Bipolar Disorder	Yes _____	No _____
Sleep Apnea	Yes _____	No _____	Easy Bleeding	Yes _____	No _____
Heartburn or Indigestion	Yes _____	No _____	Easy Bruising	Yes _____	No _____
Nausea or Vomiting	Yes _____	No _____	Sickle Cell Disease or Trait	Yes _____	No _____
Change in Abdominal Girth	Yes _____	No _____	Lymph Node Enlargement	Yes _____	No _____
Diarrhea	Yes _____	No _____	Immune Deficiency	Yes _____	No _____
Constipation	Yes _____	No _____	HIV	Yes _____	No _____
Blood in Stool	Yes _____	No _____	Hepatitis C	Yes _____	No _____

Have you had or do you have any other illness or conditions that we did not ask about in the list above?

Do Not Write Below This Line Nurse & Physician Notes
