UROLOGY SPECIALISTS CLINIC & SURGICAL CENTER

Date: _____

Patient: _____ **DOB:** _____ **Chart #:** _____

1.) Medication Allergies: _____

2.) Other Allergies (Iodine, Contrast Dye, Latex, Shellfish, etc.): _____

3.) Previous Surgeries and Major Illnesses:

_____ _____

_____ _____

4.) Social History:

Employment: _____ Marital Status: _____

Smoking History _____ packs per day for _____ years; I quit _____ years ago.

Drinking History _____ drinks per day; Type of alcohol _____

5.) Family History (alive or deceased, age, major medical illness):

Mother: _____ Father: _____

Brother(s): _____ Sister(s): _____

Has anyone in your family ever had prostate cancer? (Please state relationship, age, treatment)

_____

6.) Past Medical History - *Please indicate whether you have been treated for or diagnosed with any of the following conditions.*

Genitourinary	**Endocrine**	**Hematological/Lymphatic**
☐ Bladder Infection	☐ Hot Flashes	☐ Bleeding Disorder
☐ Bladder Stone	☐ Extreme Thirst	☐ Low Blood Count
☐ Blood in Urine (Hematuria)	☐ Diabetes	☐ Enlarged Lymph Nodes
☐ BPH	☐ Extreme Tiredness	☐ Hepatitis
☐ Erectile Dysfunction	☐ Hyperthyroidism	☐ HIV/AIDS
☐ Interstitial Cystitis	☐ Hypothyroidism	☐ Other:
☐ Kidney Cancer	☐ Other:	☐
☐ Kidney Stone		**Gastrointestinal**
☐ Nocturia (Night Urination)	**Cardiac**	☐ Abdominal Pain
☐ Not Emptying (Retention)	☐ Coronary Artery Disease	☐ Heartburn
☐ Prostate Cancer	☐ Heart Attack	☐ Nausea and/or Vomiting
☐ Sexually Transmitted Disease	☐ Rhythm Disorder	☐ Other:
☐ Testicular Cancer	☐ High Blood Pressure	☐
☐ Testicular Pain	☐ Peripheral Vascular Disease	**General**
☐ Transplant Donor or Recipient	☐ Other:	☐ Anxiety or Depression
☐ Trauma - Kidney, Groin, Testicle	☐	☐ Chills or Fevers
☐ Urinary Frequency	**Pulmonary**	☐ High Cholesterol
☐ Urinary Incontinence (Leaking)	☐ Asthma	☐ Insomnia
☐ Urinary Urgency	☐ COPD/Emphysema	☐ Obesity
☐ Urinary Tract Infection (UTI)	☐ Lung Cancer	☐ Unexplained Weight Loss/Gain
☐ Vasectomy	☐ Other:	☐ Other:
☐ Weak Stream	☐	☐
☐ Other:	☐	☐

PLEASE CONTINUE TO SIDE 2

MEDICATIONS (INCLUDING OVER-THE-COUNTER, HERBALS & VITAMINS):

Preferred Pharmacy Name: _____

Address/City/State: _____

Mail Order Pharmacy Name: _____

CURRENT PRESCRIPTION MEDICATION(S) - *If you have a current list, you may photocopy and attach.*

NAME OF MEDICATION	DOSE & FREQUENCY	WHO PRESCRIBED

CURRENT OVER-THE-COUNTER MEDICATION, VITAMINS, HERBALS:

NAME	DOSE & FREQUENCY