UROLOGY SPECIALISTS CLINIC & SURGICAL CENTER

Date: _____

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

1.) Medication Allergies:_____ **Reaction:** _____

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

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