Patient Information

Name _____ Date of Birth _____

Who referred you to us? _____

Reason for visit: _____

_____

HISTORY

Describe Symptoms: _____

_____

Previous Treatments: _____

_____

Any recent lab tests or X-rays (where and when)? _____

_____

_____

Previous urology evaluation: _____

Recent ER visit? _____

PAST MEDICAL HISTORY

Y: Yes or N: No

Y	or	N		Y	or	N	
❍		❍	Diabetes	❍		❍	Vasectomy
❍		❍	High Blood Pressure	❍		❍	Hysterectomy
❍		❍	Glaucoma	❍		❍	Appendix Removal
❍		❍	Kidney Disease	❍		❍	Gallbladder Removal
❍		❍	Kidney Stones	❍		❍	Hernia Surgery
❍		❍	Radiation Therapy	❍		❍	Chemotherapy
❍		❍	Prostate, Kidney, or Bladder Cancer				

Other Illnesses: _____

_____

_____

Other Surgeries: _____

_____

_____

Previous Hospitalizations (Date and Place): _____

_____

List all present medications, dosages and reasons for use (include non-prescription drugs such as aspirin).

Drug: _____ Dose: _____ Drug: _____ Dose: _____

Drug: _____ Dose: _____ Drug: _____ Dose: _____

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Drug: _____ Dose: _____ Drug: _____ Dose: _____

Drug: _____ Dose: _____ Drug: _____ Dose: _____

List all allergies, particularly medication and food allergies:

Allergic to iodine? ____Yes ____No Reaction: _____

Allergic to seafood? ____Yes ____No Reaction: _____

Allergic to: _____ Allergic to: _____

Allergic to: _____ Allergic to: _____

Have You Ever Had?

Cancer: ___Bladder ___Prostate ___Skin Other: _____

Diabetes: ___Type I ___Type II ___III ___Insulin

Nephritis (Bright's Disease) _____

Kidney Stones: _____

Bleeding Tendencies: _____

Heart Trouble: ___Yes ___No ___Attack ___By-Pass ___Pace Maker Other: _____

High Blood Pressure: Yes No Stroke Other:

Do you smoke? ○ Yes ○ No ○ Quit _____ years ago

If yes, how many packs per day? _____

How many years? _____

Do you drink alcoholic beverages? ○ Yes ○ No ○ Quit _____ years ago

If yes, how much? _____

Do you drink caffeinated beverages? ○ Yes ○ No

If yes, how much per day (ounces, cups)? _____

NAME _____ DATE _____