ATLANTIC UROLOGICAL ASSOCIATES
545 Health Blvd.
Daytona Beach, FL 32114
(386) 239-8500

Date:_____ Name:_____ Age:_____

GENERAL REVIEW OF PERSONAL HISTORY: (a copy of this may be added to your hospital record)

Describe any non-urologic symptoms you presently have:

Depression or anxiety:_____

Neurologic (e.g. weakness, numbness, dizziness, seizures):_____

Eyes (glaucoma, double vision):_____

Ears, nose, throat, sinuses:_____

Endocrine (e.g. diabetes, thyroid trouble):_____

Respiratory (e.g. shortness of breath, asthma, bronchitis, bloody sputum):_____

_____

Cardiovascular (e.g. angina, palpitations, congestive failure):_____

_____

Gastrointestinal (e.g. stomach, intestines, gallbladder, liver):_____

_____

Other:_____

_____

Are you an "easy bleeder" ❒ yes ❒ no Have you ever had a blood transfusion ❒ yes ❒ no

List any past operations and approximate dates:

Operation:_____ Date:_____ Operation:_____ Date:_____

Operation:_____ Date:_____ Operation:_____ Date:_____

Operation:_____ Date:_____ Operation:_____ Date:_____

List any past serious illnesses and approximate dates:

Illness:_____ Date:_____ Illness:_____ Date:_____

Illness:_____ Date:_____ Illness:_____ Date:_____

Illness:_____ Date:_____ Illness:_____ Date:_____

List all present medications, dosages and reasons for use (include non-prescriptions drugs taken frequently also (e.g. Aspirin):

Drug:_____ Dose:_____ Reason:_____

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Drug:_____ Dose:_____ Reason:_____

List all allergies, particularly medication and food allergies:

Allergic to iodine? ❒ yes ❒ no Reaction:_____

Allergic to seafood? ❒ yes ❒ no Reaction:_____

Allergic to:_____ Reaction:_____

Allergic to:_____ Reaction:_____

Allergic to:_____ Reaction:_____

Do you smoke cigarettes? ❒ yes ❒ no How much per day?_____ How many years?_____

Did you ever smoke a pack or more a day? ❒ yes ❒ no How many years?_____

Do you drink alcohol? ❒ yes ❒ no Type ❒ wine ❒ beer ❒ liquor How much a day?_____

What is your present or former occupation?_____

FAMILY HISTORY

Cancer:	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather
Diabetes:	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather
Nephritis (Bright's disease):	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather
Kidney Stones:	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather
Bleeding Tendencies:	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather
Heart Trouble:	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather
High Blood Pressure:	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather

Other:_____

_____

Mother: ❒ living age:_____ ❒ deceased/age of death:_____ cause of death:_____

Father: ❒ living age:_____ ❒ deceased/age of death:_____ cause of death:_____

Sister(s): number living:_____ age(s):_____

number deceased:_____ age(s) at death:_____ cause of death:_____

Brother(s): number living:_____ age(s):_____

number deceased:_____ age(s) at death:_____ cause of death:_____

Children: number living:_____ age(s):_____

number deceased:_____ age(s) at death:_____ cause of death:_____