AUI
ADVANCED UROLOGY INSTITUTE

PATIENT MEDICAL INFORMATION SHEET

NAME(nombre):_____DOB(Fecha de nacimiento):_____
DATE(fecha):_____

MEDICATION ALLERGIES (MEDICAMENTOS ALERGIAS): (Circle/Fill all that apply)

Bactrim	Codeine	Penicillin	Sulfa
Cipro/Levaquin	Nitrofurantoin	Hydrocodone	Tetracycline
Statins	Latex	IV Dye/Iodine	NO ALLERGIES

Other: _____

SOCIAL HISTORY (Historia Social):
Recreational Drug Use (Uso de drogas recreativas): Current / Past / Never
Smoking(fumar): Currently Past Never Packs/day:_____ Quit:_____
Alcohol: Currently Past Never Drinks/day:_____ Quit:_____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm. (Lista todos los medicamentos usted toma, incluyendo vitaminas y medicamentos de venta libre (OTC). Incluyen dosis específicas y cuando se toma. Si no sabes, por favor llame a su farmacéutico para confirmar.)

Medications	**OTC and vitamins**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PERSONAL MEDICAL HISTORY: (Please circle all that apply) (Antecedentes personales: Por favor circule las que apliquen)

ADHD	COPD	HIV	Peptic Ulcer
Alcoholism	Dementia	Hepatitis	Psoriasis
Allergies	Depression	Hypertension	Pulmonary
Anemia	Diabetes: 1or 2	Kidney Stones	Prostate Cancer
Arthritis	Diverticulitis	Kidney Disease	Rheumatoid
Arrhythmia	DVT (Blood Clot)	Kidney Cancer	Sciatica
Anxiety	Eczema	Lung Cancer	Seizure Disorder
Apnea	Emphysema	Lupus	Sleep Disorder
Asthma	Gallstones	Liver Disease	Stroke
Bipolar Disorder	GERD	Macular Degeneration	Thyroid Disorder
Bladder Cancer	Glaucoma	Migraines	Ulcerative Colitis
Bleeding Disorder	High Cholesterol	Nosebleeds	Urinary Incontinence

Patient Name: _____

Surgical History: Please list all prior surgeries and approximate dates performed.
(Historia quirúrgica: Enumere todas las cirugías previas y fechas aproximadas realizadas.)

_____

_____

_____

_____

_____

FAMILY HISTORY (HISTORIA DE LA FAMILIA):
FATHER (padre): Living(viven): Age_____ Deceased(muertos): Age_____

COPD/Emphysema Colon Cancer Stroke Heart Disease
Breast Cancer Bladder Cancer Kidney Disease Prostate Cancer
High Blood Pressure Diabetes 1 or 2
Other (otros): _____

MOTHER (madre): Living(viven): Age_____ Deceased(muertos): Age: _____
COPD/Emphysema Colon Cancer Stroke Heart Disease
Breast Cancer Bladder Cancer Kidney Disease High Blood Pressure
Diabetes 1or2
Other (otros): _____

Siblings(hermanos)**: _____**

List other medical providers you see on a regular basis (i.e. Cardiologist, Medical Health Provider, Pulmonologist, etc.) (Lista de otros proveedores de servicios médicos que ver sobre una base regular)

Primary Care Physician (médico de atención primaria)**: _____**

Cardiologist (cardiólogo)**: _____**

Pumonologist (pumonologist)**: _____**

Other (otros)**: _____**

Preferred Pharmacy (farmacia preferida):**_____**

Phone Number (número de teléfono)**: _____**

Patient signature (firma del paciente): _____

Date (fecha): _____