

NAME _____ OCCUPATION _____

Please take the time to accurately complete this form.

It is very important that we have an accurate medical history to provide you with the best urologic care.

PAST/CURRENT ILLNESSES

- Asthma
- Drug/Alcohol problems
- TB (Tuberculosis)
- Kidney Stones
- Heart Problems
- High Cholesterol
- Rheumatic Fever
- Diabetes
- Stroke
- Cancer—TYPE _____
- Anemia
- Prostate Problems
- Ulcers
- Mental Illness
- Seizures
- Depression
- Back Problems
- Thyroid disease
- Gall stones
- Hepatitis—A B C
- Liver problems
- Bleeding problems
- Skin problems
- Hearing loss
- Sexually transmitted diseases
- HIV or AIDS
- Headaches
- Vision problems
- High Blood Pressure
- Other _____

ALLERGIES

Please check any allergies that you have had and write down the reactions.

- Penicillin _____
- Sulfa _____
- Aspirin _____
- Codeine _____
- Bee Stings _____
- Foods _____
- Other _____

ALCOHOL USE _____ TYPE _____
Amount _____ How Often _____

TOBACCO USE—YES __ NO __ QUIT _____
TYPE _____ Amount per day _____

SURGERIES

- Appendix _____
- Gall bladder _____
- Other _____
- Tonsils _____
- Breast _____

HOSPITALIZATIONS

Please list dates and reasons for all hospitalizations.

DATE	REASON

FAMILY HISTORY

Please list any diseases, and family member who has/had it, that run in the family.

MEDICATIONS

Please list any medications you take, both prescription and over-the-counter. Give dosage and how often taken:

I hereby certify that the above information is accurate and complete: _____
(signature)