Patient Medical Information Form

Name _____ Date_____
Reason You Are Seeing The Urologist:_____

Do you currently, or have you had any of the following medical problems?

General Health			Gastrointestinal		
Fever	yes	no	Abdominal pain	yes	no
Chills	yes	no	Vomiting	yes	no
Weight loss	yes	no	Black or bloody stools	yes	no
Cardiovascular			**Musculoskeletal**		
Chest pain	yes	no	Arthritis	yes	no
High blood pressure	yes	no	Joint pain	yes	no
Heart Attack	yes	no	Spinal pain	yes	no
Respiratory			**Neurologic**		
Wheezing	yes	no	Stroke	yes	no
Shortness of breath	yes	no	Seizures	yes	no
Coughing up blood	yes	no	Fainting	yes	no
Skin			**Endocrine**		
Rash	yes	no	Diabetes	yes	no
Boils	yes	no	Thyroid trouble	yes	no
Persistent itch	yes	no	Pituitary disease	yes	no
Hematologic			**Allergic**		
Bleeding problems	yes	no	Hayfever	yes	no
Swollen glands	yes	no	**Are you Allergic to any Medications?**	**yes**	no

_____

Past Medical History (**Please List With Dates**)

Medical Illnesses/Hospitalizations

_____
_____
_____
_____
_____

Operations

_____
_____
_____
_____
_____

Current Medications

_____
_____
_____
_____
_____ **daily aspirin?** yes no

(how much?)

Do you smoke cigarettes? no yes→_____
Are you an ex-smoker? no yes
Do you drink alcohol? no yes→_____

Occupation: _____

Please list any **significant family history** of illness, cancer, kidney/bladder/prostate diseases

_____
_____