

# ZUROLOGY

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NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

List of Reasons for today's visit: \_\_\_\_\_

## **MEDICAL HISTORY**

Prior Illnesses and Serious Injuries: \_\_\_\_\_

Prior Surgeries: \_\_\_\_\_ Date \_\_\_\_\_

Prior Surgeries: \_\_\_\_\_ Date \_\_\_\_\_

Prior Hospitalizations: \_\_\_\_\_ Date \_\_\_\_\_

Prior Hospitalizations: \_\_\_\_\_ Date \_\_\_\_\_

Please list all the medications you are currently taking: \_\_\_\_\_

Allergies and Reactions (Drug, Food, Or Other) : \_\_\_\_\_

Sexually Transmitted Diseases: \_\_\_\_\_

## **FAMILY MEDICAL HISTORY**

Urology Disease (i.e. Kidney stones, incontinence) \_\_\_mother \_\_\_father \_\_\_other: \_\_\_\_\_

Please Specify : \_\_\_\_\_

Cancer \_\_\_mother \_\_\_father \_\_\_other: \_\_\_\_\_

Please Specify : \_\_\_\_\_

## **Social History**

Marital Status: \_\_\_Single \_\_\_Married \_\_\_Divorced \_\_\_Widowed \_\_\_Cohabiting

Living Situation \_\_\_Living at Home \_\_\_Nursing Home \_\_\_Homeless \_\_\_Other

Occupation: \_\_\_\_\_

Tobacco Use: \_\_\_Non Smoker \_\_\_Smoker: Packs Per Day: \_\_\_\_\_

Alcohol Use: \_\_\_Non Drinker \_\_\_Yes, I Drink \_\_\_\_\_Ounces Per day