UROLOGY

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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 ____Cohabitating

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

Drug Use: ___Non User ___User Type: _____