PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

LAST NAME _____ FIRST NAME: _____ DOB: _____ DATE: _____

Why are you consulting a Urologist? _____

Medical History

Medical ☐ None (*High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.*)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Females: How many pregnancies ___ How many children ___ **Males:** Last prostate and/or rectal exam_____

Surgery ☐ *None (Type and Year)*

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Allergies to medications? ☐ None (If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)

_____

_____

Current prescription medicines ☐ **None**

Name of drug	mg dose	# tablets	# times per day

Current prescription medicines

Name of drug	mg dose	# tablets	# times per day

OTC medicines. (Aspirin, Tylenol, Ibuprofen, Aleve, vitamins and herbals.)

_____ _____ _____ _____

Family History

	Living	Deceased	Illness	Cause of Death/Age
Father	☐	☐		
Mother	☐	☐		
Sister (s)	☐# ___	☐# ___		
Brother (s)	☐# ___	☐# ___		

Family History of:	Yes	No	Family Member		Yes	No	Family Member
1. Cancer	☐	☐		2. Arthritis	☐	☐	
3. Heart Disease	☐	☐		4. Blood Disease	☐	☐	
5. Diabetes	☐	☐		6. Lung/pulmonary disease	☐	☐	

Social History

Do you smoke? Yes ☐ No ☐ For how many years? _____ How many per day? _____

Have you ever smoked? Yes ☐ No ☐ For how many years? _____ How many per day? _____

When did you stop? _____

Do you routinely exercise? Yes ☐ No ☐

Caffeine consumption: Coffee: Cups per day: _____ Tea: Cups per day: _____

Other: _____

Alcohol consumption: Type: _____ Amount: _____ Per _____

Type: _____ Amount: _____ Per _____

Dietary restrictions: _____

_____

_____