WK ADVANCED UROLOGY

PATIENT HISTORY FORM

Name _____ D.O.B. _____

Did another physician refer you to this office? **O** YES **O** NO If yes, whom: _____

Primary Care Physician: _____ phone #: _____

What Cardiologist/Pulmonologist do you see? _____
Location:_____

What is your pharmacy of choice? _____ phone #_____

What is the reason for today's visit? _____

PAST MEDICAL HISTORY

Do you have or have had any of the following problems?

- O Aids
- O Arthritis
- O Asthma
- O Back Problems
- O Enlarged Prostate
- O Bleeding Disorder
- O Bronchitis/Emphysema
- O Cancer _____
- O Cataracts
- O Stroke
- O Chronic UTI's
- O Colitis
- O Congestive Heart Failure
- O COPD
- O Crohn's Disease
- O Heart Disease
- O Depression
- O Diabetes
- O Diverticulitis
- O GERD
- O Glaucoma
- O Gout
- O Hepatitis
- O High Blood Pressure
- O HIV positive
- O IBS
- O IV Drug Use (Ever)
- O Liver Disease
- O Lupus
- O Mental Illness
- O Migraines
- O Heart Attack
- O Alcoholism
- O Osteoarthritis
- O Osteoporosis
- O Parkinson's Disease
- O Peptic Ulcer Disease
- O Psoriasis
- O Kidney failure
- O Rheumatoid arthritis
- O Rheumatic Fever
- O Seizure disorder
- O MS
- O Sickle Cell Disease
- O Spinal Injury
- O Thyroid Disease
- O Tuberculosis
- O Kidney stones

PAST SURGICAL HISTORY

Have you had any procedures or surgery in your life? **O** YES **O** NO
If yes, please list **type** of procedures or surgeries and **approximate date**

_____

_____

OB/GYN HISTORY

Last Menstrual Period (if applicable) _____
# of Pregnancies _____ # of Vaginal Deliveries _____ # of C-Sections _____

ALLERGIES

Are you allergic to any **medications**, shellfish or iodine? **O** YES **O** NO
If yes, please **list and describe your reaction** to the medication (hives, rash, etc.):

_____

_____

MEDICATIONS

Do you regularly take prescription or non-prescription medication? **O** YES **O** NO
If yes, please list all medicine, dosage and how many times per day:

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

Has any relative (mother, father, sister, brother, paternal or maternal grandparents, maternal or paternal aunts or uncles) ever had any of the following? If so, please check and state relation:

O Asthma _____
O Blood Disease _____
O Cancer (specify type) _____
O Stroke _____
O Heart Disease _____
O Diabetes _____
O Gout _____
O High Blood Pressure _____
O Migraines _____
O Renal Failure _____
O Thyroid Disease _____
O UTI's _____
O Kidney Stones _____
O Other (specify condition) _____ _____

SOCIAL HISTORY

What is your marital status? [ ] Married [ ] Single [ ] Divorced [ ] Widowed
Do you or have you ever smoked? [ ] Yes [ ] No If yes, how many packs per day? _____
How many years have you been smoking? _____ If you quit, what year did you quit? _____
Do you drink alcohol? [ ] No [ ] Yes Number of drinks per week _____

Are you currently employed? [ ] Yes [ ] No Present or past occupation_____
What are your hobbies? _____

Name _____ D.O.B. _____