

Patient Information

Name: _____
First MI Last

Gender: M F **Date of Birth:** ____________ **SSN#:** ____-____-____

Email Address (for appointment reminders only): _____

Phone Numbers: Please check the number you prefer we call.

- Home () -
- Mobile () -
- Work () -

Marital Status: M W S D

Mailing Address: _____
Street City, State Zip Code

Physical Address (if different): _____

Next of Kin: _____ Is this person the **legal guardian?** Y N
Name Phone #

Primary Care Doctor: _____ **Referring Doctor:** _____

Surgical History Please list all operations you have had and the year they were performed.

Check here if you have never had an operation.

Operation	Year

Attach additional sheet if necessary.

Medical History Please **CIRCLE** IF you have problems with the following:

- Fever, chills, weight gain, weight loss, fatigue
- Blurred or double vision
- Dry mouth, trouble hearing
- Ankle swelling (edema), chest pain
- Cough, shortness of breath
- Back pain
- Diarrhea, constipation, nausea, vomiting
- Blood in the urine, trouble urinating
- Pelvic pain, urethral discharge, testicular pain or swelling or vaginal discharge or bulge
- Skin rash
- Numbness, tingling, trouble walking
- Anxiety, depression
- Excessive thirst, hot flashes, low sex drive
- Swollen lymph nodes, easy bruising or bleeding
- Frequent infections

- Glaucoma
- High blood pressure, high cholesterol, heart attack, coronary artery disease
- COPD, asthma, emphysema
- Arthritis, gout, back injury
- Reflux/heartburn
- Kidney stones, kidney failure
- Melanoma
- Stroke, paralysis, dementia
- Diabetes, thyroid disease
- Tuberculosis, hepatitis
- Cancer, AIDS/HIV

Check here If no other medical illnesses or list any additional illnesses.

Please complete the front **and back** of this form.

Family History

Please check if you have had **BLOOD RELATIVES** with the following illnesses, and **specify which family member** had the illness.

- | | |
|--|--|
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Breast cancer |
| <input type="checkbox"/> Prostate cancer | <input type="checkbox"/> Non-urologic cancer |
| <input type="checkbox"/> Bladder cancer | <input type="checkbox"/> Kidney failure |
| <input type="checkbox"/> Kidney cancer | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Trouble with anesthesia |
| <input type="checkbox"/> No family members with kidney, bladder, or prostate disease, cancer, bleeding problems, or trouble with anesthesia. | |

Social History Please check which of the following you have ever used and use currently, and provide details if used.

	Never used	Ever used?	Still use?	Form used (ie, cigarettes, wine, marijuana)	Years used	How much (ie, packs per day, drinks per day)
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		to	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		to	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		to	

Where do you live? Home with family Home alone Facility (which?) _____

Are you sexually active? Yes No

Are you? Working Retired Disabled Student

What type of work do/did you do? _____

Nutrition History

Do you follow a special diet? Yes or No Which? _____

How many cups of caffeine do you drink a day? _____

Medications Please list all medications you take and the dose. Include supplements and over-the-counter medications.

Check here if not taking any medications or over-the-counter supplements, vitamins, or medications.

Medication	Dose	How often? (ie, once a day, twice a day)

Attach additional sheet if necessary.

Allergies Please list any allergies to medications and the reaction you had. Check here if no allergies.

Allergy	Reaction	Circle severity
		Very mild, mild, moderate, severe
		Very mild, mild, moderate, severe
		Very mild, mild, moderate, severe

Attach additional sheet if necessary.

Person Completing Form: _____ Relationship to Patient: _____ Date: _____