The UROLOGIST

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NAME: _____ **EMAIL:** _____ **DATE:** _____

PLEASE DESCRIBE THE REASON FOR YOUR VISIT TODAY:

_____

WHAT PREVIOUS MAJOR MEDICAL EVENTS, HOSPITALIZATIONS, AND SURGERIES HAVE YOU HAD (WITH DATES)?

MARK WITH AN "X" IF YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ COPD ☐ HEART STENTS OR OPERATION

MARK WITH AN "X" AND EXPLAIN IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF FOLLOWING CONDITIONS:

☐ CANCER
☐ HEART CONDITION
☐ LUNG CONDITION
☐ VASCULAR
☐ GASTROINTESTINAL CONDITION
☐ EYE, EAR, NOSE, THROAT
☐ SKIN
☐ NEUROLOGIC
☐ **UROLOGIC CONDITIONS**

WHAT MEDICATIONS ARE YOU TAKING ON A REGULAR BASIS? PLEASE INCLUDE OVER-THE-COUNTER DRUGS SUCH AS ASPRIN, MOTRIN, AND VITAMINS (PLEASE USE ADDITIONAL PAGE IF REQUIRED):

MEDICINE	FREQUENCY	DOSE	MEDICINE	FREQUENCY	DOSE

LIST ALL ALLERGIES INCLUDING MEDICATIONS/SUBSTANCES (PLEASE USE ADDITIONAL PAGE IF REQUIRED):

MEDICINE	TYPE OF REACTION	MEDICINE	TYPE OF REACTION

DO YOU OR DID YOU EVER SMOKE: YES ◯ NO ◯ **IF YES, HOW MANY PACKS PER DAY?** ____ **NO. OF YEARS:** ____

DO YOU HAVE ANY DISEASE(S) THAT RUN IN YOUR FAMILY?

☐ PROSTATE CANCER ☐ TESTICULAR CANCER ☐ KIDNEY CANCER ☐ OTHER: _____

FAMILY HISTORY (PLEASE LIST PRESENT STATE OF HEALTH OR CAUSE OF DEATH):

Relation	Health If Alive	Cause If Deceased	**Relation**	Health If Alive	Cause If Deceased
Father			**Mother**		
Brother/s (No.)			**Sister/s (No.)**		
Son/s (No.)			**Daughter/s (No.)**		