Comprehensive Urology
www.urologist.org

Name: _____
Date of Birth: _____ / _____ / _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Pharmacy Name: _____
Pharmacy Phone: _____

Date: _____

Referred by: Doctor _____ Family/Friend _____

Family Physician (Internist): _____

Occupation: (Present) _____

Occupation: (Previous) _____

Employer:

Person to notify in case of emergency: _____ Phone # _____

Relationship to patient: _____

List all your MEDICATIONS, DOSAGES and FREQUENCY (if known):

MEDICATIONS	DOSAGES	FREQUENCY	MEDICATIONS	DOSAGES	FREQUENCY
	mg.			mg.	
	mg.			mg.	
	mg.			mg.	
	mg.			mg.	

Do you take BLOOD THINNERS, COUMADIN, PLAVIX or ASPIRIN products or other over the counter PAIN MEDICATIONS on a regular or daily basis? If so, please list below.

MEDICATIONS	DOSAGES	FREQUENCY	MEDICATIONS	DOSAGES	FREQUENCY
	mg.			mg.	
	mg.			mg.	

List all known ALLERGIES to medications / Iodine / X-ray dye / latex etc...

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY

Diagnosis / Condition			Diagnosis / Condition			Diagnosis / Condition		
Heart Attack	Y	N	Breathing Problems	Y	N	Diabetes	Y	N
Angina	Y	N	Asthma	Y	N	Liver Disease	Y	N
Stroke	Y	N	Kidney Disease	Y	N	Hepatitis	Y	N
High Blood Pressure	Y	N	Kidney Stones	Y	N	Neurologic Disease	Y	N
Irregular/Rapid Heart Beat	Y	N	Thyroid Disease	Y	N	Cancer	Y	N
						Type:		

FAMILY HISTORY

Prostate Cancer	Y N	Bladder Cancer	Y N	Kidney Cancer	Y N	Kidney Disease	Y N
Kidney Stones	Y N	Colon Cancer	Y N	Heart Disease/Attack	Y N		

Other:

SOCIAL HISTORY

Do you exercise? Y N Amount _____
Do you smoke? Y N Amount _____
Do you drink Alcohol? Y N Amount _____
Do you drink caffeine? Y N Amount _____

Is your problem ( ) work or ( ) accident related?
Contact name and number_____

Is there an attorney or case worker working with you?
Contact name and number_____

Are you currently in a nursing home? Y N

SURGICAL HISTORY List all surgical procedures that you have had and the approximate dates.

REVIEW OF SYSTEMS

Constitutional Symptoms
- Fever Y N
- Chills Y N
- Headache Y N
- Other _____

Eyes
- Blurred vision Y N
- Double vision Y N
- Pain Y N
- Other_____

Allergic/Immunologic
- Hay Fever Y N
- Drug Allergies Y N
- Other_____

Neurological
- Tremors Y N
- Dizzy Spells Y N
- Numbness/tingling Y N
- Other_____

Endocrine
- Excessive thirst Y N
- Too hot/cold Y N
- Tired/sluggish Y N
- Other_____

Gastrointestinal
- Abdominal pain Y N
- Nausea/vomiting Y N
- Indigestion/heartburn Y N
- Other_____

Cardiovascular
- Chest pain Y N
- Varicose veins Y N
- High blood pressure Y N
- Other_____

Integumentary
- Skin rash Y N
- Boils Y N
- Persistent itch Y N
- Other_____

Musculoskeletal
- Joint pain Y N
- Neck pain Y N
- Back pain Y N
- Other_____

Ear/Nose/Throat/Mouth
- Ear infection Y N
- Sore throat Y N
- Sinus problems Y N
- Other_____

Genitourinary
- Urine retention Y N
- Painful urination Y N
- Urinary frequency Y N
- Other_____

Respiratory
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Other_____

Hematologic/Lymphatic
- Swollen glands Y N
- Blood clotting problem Y N
- Headache Y N
- Other_____

Psychologic
- Are you generally satisfied with your life? Y N
- Do you feel severely depressed? Y N
- Have you considered suicide? Y N
- Other_____

I certify that the above information is correct to the best of my knowledge.

It is my responsibility to call the office for all test results one week after the test is performed.

Patient or Legal Guardian Signature: **X**_____ Date: _____

Reviewed by: _____ Date: _____ / _____ / _____

Form No. CU 5003
Rev. 3/14