

Patient History Form

Date: _____

Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

Reason for Visit (please describe): _____

Do you have any of the following medical conditions?

Please include any conditions for which you are currently taking medication.

High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Heart Conditions	Yes	No
Type I Diabetes	Yes	No
Type II Diabetes	Yes	No
Dementia	Yes	No
Depression	Yes	No
Anxiety	Yes	No

Other (please specify) _____

Please List All Known Allergies

Current Medications (Please Include Prescriptions, Over-the-Counter, and Vitamins)

Name	Dosage	Frequency
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Social History

Do use tobacco? Yes No

If Yes, what type?

Cigarettes (_____ Packs/Day)

Cigars/Pipes

Smokeless

Do you drink alcohol? Yes No

If yes, how much? (_____ Drinks/Day)

Do you have any of the following urological conditions?

Please include any conditions for which you are currently taking medication.

Blood in Urine	Yes	No
Painful Urination	Yes	No
Kidney Stones	Yes	No
Frequent Urination at Night	Yes	No
Urinary Frequency	Yes	No
Incontinence	Yes	No
Urinary Urgency	Yes	No
Incomplete Bladder Emptying	Yes	No

Herpes Yes No

Hepatitis (A, B, or C) Yes No

HIV Yes No

Other (please specify) _____

Past Surgeries (Please Include Dates)

Family History

Have any of Your Parents or Siblings
Ever Had Any of the Following:

Condition	Member
Cancer	Yes No _____
Type I Diabetes	Yes No _____
Type II Diabetes	Yes No _____
High Cholesterol	Yes No _____
Thyroid Problems	Yes No _____
Dementia	Yes No _____
Heart Disease	Yes No _____
Heart Attacks	Yes No _____
Strokes	Yes No _____
High Blood Pressure	Yes No _____