Urology PC Health History

Date:	Name:	DOB:	Sex:	Ht:	Wt:
REASON FOR VISIT:		**Preferred Pharmacy Name & Address:**			

Please circle YES or NO for each of the following:

Have you had a flu shot? NO YES When? _____
Pneumonia Vaccination? NO YES When?_____

List all Current Medications and dose including over-the-counter, aspirin meds, fish oil, inhalers and vitamins.

List all Allergies to medications and your reactions. ☐ **None**

	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown

Allergy to Latex? NO YES **Allergy to Iodine?** NO YES

Please List all Previous Surgeries and year performed. ☐ None

Surgery	Year	Surgery	Year

Have you ever had a Colonoscopy? NO YES What year was it performed?_____

Personal Alcohol Use: ☐ None How Much:_____ How Often:_____

Personal Caffeine Use: ☐ None How Much:_____ How Often:_____

Tobacco Use: (please circle) Never Current Former Age Quit? _____
Type: Cigarettes Cigar Pipe Smokeless How much daily? _____

(OVER →)

Personal Past Medical History: (please circle appropriate answer)

Cancer: NO YES **Type of Cancer:**_____ **Treatment:** Surgery Chemo Radiation

Anemia: NO YES	**Arthritis:** NO YES	**Asthma:** NO YES
COPD/Emphysema/ Chronic Bronchitis: NO YES	**Diabetes:** NO YES If yes, do you take medication for this? NO YES	**Heart Disease (bypass/ stent, surgery):** NO YES
Heart Rhythm Problems NO YES	**Hepatitis / Liver Disease:** NO YES	**High Blood Pressure:** NO YES
History of Seizure: NO YES	**History of Stroke or TIA:** NO YES	**HIV:** NO YES
Kidney Disease: NO YES	**Multiple Sclerosis:** NO YES	**Muscular Dystrophy:** NO YES
Osteoporosis: NO YES	**Pacemaker/Defibrillator:** NO YES	**Parkinson's:** NO YES
Systemic Lupus: NO YES	**Thyroid Problems:** NO YES	**Urinary or Kidney Stones:** NO YES

Family Cancer History: (Please indicate type and family member) ☐ None

	Cancer	Cancer	Cancer	Cancer
What family member?				
What type?				

☐ I was adopted and have no available health history.

Total or Partial Joint Replacement NO YES

If yes, What joint? _____ When was surgery?_____

If yes, have you been told to take antibiotics prior to surgery or dental procedures? NO YES

Anyone in your family have issues with anesthesia: NO YES

If patient is 19 or younger:

Was patient born prematurely? NO YES If yes, how many weeks early?_____
Any developmental delays as a child? NO YES

Form Completed by: _____ Date: _____

(OVER →)