Urology PC Health History

Date:	Name:	DOB:	Ht:	Wt:

Current Gender:	Gender Identity:	Preferred Pronoun:

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**

Allergy	Reaction	Allergy	Reaction
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown

Allergy to Latex? NO YES
Have you had a reaction to or do you have an allergy to Iodine? NO YES
Have you ever had an antibiotic resistant infection such as MRSA or VRE? NO YES if Yes circle, ACTIVE HISTORY OF

Please list all **SURGERIES** in the last year. ☐ **None**

Surgery	Year	Surgery	Year

Tobacco Use: (please circle) Never Current Former Age Quit? _____

Type: Cigarettes Cigar Pipe Smokeless How much daily? _____

Diabetes: NO YES If yes, do you take medication for this? NO YES	**Heart Disease (bypass stent, surgery):** NO YES	**High Blood Pressure:** NO YES

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

Form Completed by: _____ Date: _____