New Patient History

Name:____ **Date**:___________________________

REFERRING DOCTOR: ________________________________ Primary Doctor __________________

Why are you seeing the doctor today? ____

Have you seen any prior urologists? ____

Current Medications (Or attach medication list)

Medication name:

_________________ ________________ ________________ ____________________

_________________ ________________ ________________ ____________________

ALLERGIES: ____

PHARMACY NAME ________________________ **ADDRESS or CROSS STREETS** ______________________

<u>FAMILY HISTORY</u> (circle and indicate which family member)

Prostate cancer **Kidney Cancer** **Kidney stones** **Other** __________

<u>SOCIAL HISTORY</u>

Marital Status: Married Single Divorced Widowed

Occupation ______________ Retired ________________

Tobacco use _______Never smoked ______ Current smoker _______Former smoker

Recreational drugs ____ none If yes, please list _______________________

Alcohol _________ drinks/day ________ former abuse __________ Socially ______ Never

Preferred Language _________________

<u>SURGICAL HISTORY</u>

List ____

____

<u>PAST MEDICAL HISTORY (circle)</u>

High blood pressure
Diabetes
Coronary Artery Disease (heart)
Heart Attack
Atrial arrythmia
Blood clot (DVT or PE)
Liver disease
Kidney Disease/ failure

Fibromyalgia
Asthma/ COPD
Diverticulosis/ Diverticulitis
Prior Radiation Treatment

Other _________________
____

New Patient History

REVIEW OF SYMPTOMS
(circle if applies)

Constitutional
Fevers
Chills

Skin
Rash
Bruising

Cardiovascular
Chest Pain
Heart Murmur

Respiratory
Cough
Shortness of Breath

GI
Nausea/vomiting
Diarrhea
Constipation

Urology (GU)
Pain with urination
Urinary frequency
Incontinence
Blood in urine

Hematologic
Anemia
Increased bruising

Musculoskeletal
Back pain
Muscle Weakness

Neurological
Seizure
Headache

Psychologic
Anxiety
Depression