ZUrology

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NAME: ______________________________________ DATE OF BIRTH: ________________

List of Reasons for today's visit: ____

MEDICAL HISTORY
Prior Illnesses and Serious Injuries: ____

____

Prior Surgeries: _______________________________________ Date ____________________

Prior Surgeries: _______________________________________ Date ____________________

Prior Hospitalizations: _________________________________ Date ____________________

Prior Hospitalizations: _________________________________ Date ____________________

Please list all the medications you are currently taking: _______________________________________

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Allergies and Reactions (Drug, Food, Or Other) : ____

____

Sexually Transmitted Diseases: ____

FAMILY MEDICAL HISTORY
Urology Disease (i.e. Kidney stones, incontinence) ____mother _____father_____other: _____

Please Specify :____

Cancer ______mother ______father ______other: ______

Please Specify :____

Social History
Marital Status: _____Single _____Married _____Divorced _____Widowed _____Cohabitating

Living Situation _____Living at Home _____Nursing Home _____Homeless _____Other

Occupation: ____

Tobacco Use: ____Non Smoker ____ Smoker: Packs Per Day: _____________

Alcohol Use: ____Non Drinker ____Yes, I Drink ____________Ounces Per day

Drug Use: ____Non User ____User Type: ____________________