

THE UROLOGY CENTER OF COLORADO

Please Print

Patient Name _____

Date of Birth _____

Height _____

Weight _____

Referring Physician _____

Reason For Visit _____

Today's Date _____

YOUR MEDICAL HISTORY: Circle if yes:

Cardiac:

Heart Valve*

Heart Attack*

Rheumatic Fever*

High Blood Pressure

Congestive Heart Failure

Atrial Fibrillation

High Cholesterol

Defibrillator – Provide device card

Pacemaker – Provide device card

Heart Stents

Respiratory:

Asthma

Clots in lungs*

COPD

Sleep Apnea

Emphysema

Digestive:

GERD

Irritable bowel syndrome

Peptic Ulcers

Ulcerative colitis

Diverticulitis

Endocrine / Eyes:

Diabetes

Hypothyroid

Glaucoma

Hyperthyroid

Blood / Immune:

Cirrhosis

Clots in legs*

Leukemia

Rheumatoid arthritis

Scleroderma

Lymphoma

Lupus

Musculoskeletal:

Total Joint Replacement*

Osteoporosis

Fibromyalgia

Neurologic:

Stroke

MS

Spina Bifida

Parkinsons

Depression

Seizures

Alzheimers

Infectious Disease:

AIDS/HIV*

Hepatitis

Any Cancer: _____

Any Radiation: No Yes: Site on body _____

Allergies: No Circle if yes:

Penicillin Ampicillin Sulfa Bactrim Macrochantin Levaquin Cipro Iodine Tape Latex

Other: _____

PRESCRIBED MEDICATIONS			SUPPLEMENTS, HERBALS, ETC		
Name of Medication	Strength	When you take it	Name of Item	Strength	When you take it

DO YOU TAKE ANTIBIOTICS PRIOR TO PROCEDURES? ____ YES ____ NO

If yes, what is the name of the antibiotic? _____

PLEASE TURN PAGE OVER

SURGERIES: Type of surgery and approximate date:

GENITURINARY HISTORY: No **Please circle if yes**

Kidney Cancer	Kidney Stones	Prostate Infections
Prostate Cancer	Ureter Stones	Prostate Enlargement
Bladder Cancer	Bladder Stones	Infertility
Testicular Cancer	Bladder Infections	Kidney Failure

Do you leak urine when you cough or exercise? _____

Do you leak urine when you feel an urge to urinate but cannot get to the bathroom in time? _____

Do you have problems achieving or maintaining an erection? _____

FAMILY MEDICAL HISTORY:

Relationship

Cancer – Kidney / Bladder / Prostate	_____yes _____no	_____
Kidney problems / stones	_____yes _____no	_____
Blood pressure problems	_____yes _____no	_____
Bleeding problems	_____yes _____no	_____
Diabetes	_____yes _____no	_____
Asthma / Breathing problems	_____yes _____no	_____
Reaction to anesthesia	_____yes _____no	_____
Cardiac problems	_____yes _____no	_____

SOCIAL HISTORY:

Do you use tobacco? _____yes _____no If yes, packs per day? _____

Have stopped using tobacco? _____yes _____no If yes, how long did you smoke _____

Do you use alcohol? _____yes _____no If yes, how often and how much _____

Do you have a history of sexually transmitted diseases? _____yes _____no

Do you use recreational drugs? _____yes _____no What kind? _____

Retired _____, Working _____, What is / was your occupation? _____

Married / Single / Other _____

of Children _____ # Pregnancies _____ Currently pregnant _____yes _____no

Parent's current age, if alive: Mother _____ Father _____

If deceased, age & cause of death: Mother _____ Father _____

REVIEW OF SYMPTOMS: No **Please circle if yes**

<u>Constitutional:</u>	<u>Cardiac:</u>	<u>Endocrine:</u>
Fever	Chest Pain/Angina	Tired/sluggish
Chills	Palpitations/Heart racing	Excessive thirst
Headaches		
Weight Loss	<u>Digestive:</u>	<u>Blood/Immune:</u>
Chronic Fatigue	Nausea/Vomiting	Swollen glands
Sleep Disorder	Constipation	Blood clotting
	Diarrhea	

<u>Musculoskeletal:</u>	<u>Respiratory:</u>	<u>Neurologic:</u>
Neck problems	Wheezing	Numbness/tingling
Loss of sensation	Shortness of breath	Loss of strength
Rash/skin breakdown	Productive/bloody cough	

<u>Psychologic:</u>	<u>EENT:</u>	
Anxiety	Blurred Vision	Sore Throat
	Ear infections	Sinus Problems

Other _____

Physician's initial _____ Date _____