UROLOGIC Physicians P.A.

NEW PATIENT HISTORY

PATIENT NAME _____

DATE OF BIRTH _____ DATE OF VISIT _____

REFERRED BY _____ PRIMARY M.D. _____

Complete form to the best of your ability. The nurse will help you with any questions. Please print.

Prior Major Illness and Injuries

	Current Treatment
_____ Cardiovascular Disease	____yes ____no
Type _____	
SBE? _____	
_____ Cerebrovascular Disease	____yes ____no
Type: __CVA __TIA	
_____ Diabetes	____yes ____no
_____ Endocrine Disease	____yes ____no
Type: _____	
High Cholesterol	____yes ____no
Highest Serum Chol. Level _____	
Bleeding Disorder	____yes ____no
Type _____	

Other-Specify

_____

_____

_____

Current Medication/Dosage

_____

_____

_____

_____

Allergies ____yes ____no

___ Medications Type _____

Type _____

___ Foods Type _____

Type _____

Prior Operations ____yes ____no

Appendectomy	Year _____
Gall Bladder	Year _____
Inguinal Herniorrhaphy, left	Year _____
Inguinal Herniorrhaphy, right	Year _____
Lithotripsy	Year _____
Penile Implant	Year _____
Prostate Biopsy	Year _____
Prostatectomy	Year _____
Tonsillectomy	Year _____
Vasectomy	Year _____

Other, Specify

_____ Year _____

_____ Year _____

M.D. Signature _____

Prior Hospitalizations _____yes _____no

Event _____ Year _____

Event _____ Year _____

Event _____ Year _____

Event _____ Year _____

Social History

Marital Status ___ Divorced ___ Married ___ Single ___ Widowed

Current Employment ___ Full Time ___ Part Time ___ Retired ___ Unemployed

Occupational History

Type _____

Use of non-prescription drugs _____yes _____no

Type _____

Type _____

Use of Tobacco (current) _____yes _____no

Packs/day ___ <1/2 ___ 1/2-1 ___ >1

Use of Alcohol _____yes _____no

Drinks/week ___<7 ___ 7-14 ___ >14

Highest level of education

____ Grade School ____ High School or Equiv.

____ College Degree ____ Advanced Degree

Sexual History

____ Heterosexual _____ Potent

____ Bisexual _____ Sexually Active

____ Homosexual _____ Sexually Inactive

Family History _____ Known _____ Unknown

Health Status of Family Members:

Father ____ Alive & Well _____ Deceased at age _____

If deceased, cause of death _____

Mother ____ Alive & Well _____ Deceased at age _____

If deceased, cause of death _____

Brother(s) ____ Alive & Well _____ Deceased at age _____

If deceased, cause of death _____

Sister (s) ____ Alive & Well _____ Deceased at age _____

If deceased, cause of death _____

Diabetes	Kidney Disease	Prostate CA
___ Father	___ Father	___ Father
___ Mother	___ Mother	___ Brother
___ Brother	___ Brother	___ Uncle
___ Sister	___ Sister	___ Grandfather
___ Son	___ Son	___ Son
___ Daughter	___ Daughter	
___ Grandfather	___ Grandfather	
___ Grandmother	___ Grandmother	