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

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 **PREVIOUS SURGERIES** and year performed. ☐ **None**

Surgery	Year	Surgery	Year

Have you ever had a Colonoscopy? NO YES What year was it performed?_____

Personal Alcohol Use: None How Much:_____ How Often:_____

Personal Caffeine Use: None How Much:_____ How Often:_____

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

Type: Cigarettes Cigar Pipe Smokeless How much daily? _____

(OVER ➔)

Personal Past Medical History: (please circle appropriate answer)

Cancer: NO YES **Type of Cancer:**_____ **Treatment:** Surgery Chemo Radiation

Anemia: NO YES	**Arthritis:** NO YES	**Asthma:** NO YES
COPD/Emphysema/ Chronic Bronchitis: NO YES	**Diabetes:** NO YES If yes, do you take medication for this? NO YES	**Heart Disease (bypass/ stent, surgery):** NO YES
Heart Rhythm Problems: NO YES	**Hepatitis / Liver Disease:** NO YES	**High Blood Pressure:** NO YES
History of Seizure: NO YES	**History of Stroke or TIA:** NO YES	**HIV:** NO YES
Kidney Disease: NO YES	**Multiple Sclerosis:** NO YES	**Muscular Dystrophy:** NO YES
Osteoporosis: NO YES	**Pacemaker/Defibrillator:** NO YES	**Parkinson's:** NO YES
Systemic Lupus: NO YES	**Thyroid Problems:** NO YES	**Urinary or Kidney Stones:** NO YES

Family Cancer History: (Please indicate type and family member) ☐ None

	Cancer	Cancer	Cancer	Cancer
What family member?				
What type?				

☐ I was adopted and have no available health history.

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

Anyone in your family have issues with anesthesia: NO YES

If patient is 19 or younger:

Was patient born prematurely? NO YES If yes, how many weeks early?_____
Any developmental delays as a child? NO YES

Form Completed by: _____ Date: _____

(OVER ➔)