# MEDICAL HISTORY

PATIENT NAME: ____________________ DOB ____________ DATE: __________

UROLOGY PHYSICIAN NAME: ____________________ REFERRING DOCTOR: ____________________

PROBLEM/CHIEF COMPLAINT: ________________________________________

________________________________________________________________

## Medications: (name and dosage)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

(Medication) Allergies: ________________________________________

________________________________________________________________

## Medical History:

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Abnormal Pap | | | Diabetes mellitus | | | Liver disease | | |
| | | | | | | | | |
| Asthma | | | HIV/AIDS | | | Stroke | | |
| Clotting Disorder | | | Hormone problems | | | Thyroid disease | | |
| Colitis/bowel disease | | | Hypertension | | | Ulcers | | |
| Colon polyps | | | Infertility | | | Urinary tract infection | | |
| COPD | | | Kidney Disease | | | | | |

## Family History

## COMMENTS:

| **GI** | **Yes** | **No** |
|---|---|---|
| Abnormal Distention | | |
| Abnormal Pain | | |
| Anal Bleeding | | |
| Blood in stool | | |
| Constipation | | |
| Diarrhea | | |

| **Hematologic** | **Yes** | **No** |
|---|---|---|
| Adenopathy | | |
| Bruises/bleeds easily | | |

| **Psychiatric** | **Yes** | **No** |
|---|---|---|
| Agitation | | |
| Behavior Problem | | |