DEPARTMENT OF UROLOGY
PATIENT INFORMATION FORM

Patient Label

Allergies: ______________________

Current Medications ______________________

____

Reason for today's visit: (chief complaint) ______________________

____

Current or past problems with: (Review of Systems)

	Yes	No	(If yes, explain)
Asthma	____	____	______________
Diabetes	____	____	______________
Eyes	____	____	______________
Ears/Nose/Throat/Mouth	____	____	______________
Heart	____	____	______________
Lungs	____	____	______________
Stomach/Bowel	____	____	______________
Kidneys	____	____	______________
Arthritis/Muscles/Joints	____	____	______________
Skin	____	____	______________
Headache/Seizures	____	____	______________
Pyschological Disorder	____	____	______________
Thyroid	____	____	______________
Blood/Bleeding disorder	____	____	______________
Hepatitis	____	____	______________

Family History: (Past/Present)

Disease	Mother	Father	Other
Allergies	____	____	____
Arthritis	____	____	____
Asthma	____	____	____
Cancer	____	____	____

Disease	Mother	Father	Other
Diabetes	____	____	____
Heart Disease	____	____	____
High Blood Pressure	____	____	____
Lung Disease	____	____	____

Social History:

	Yes	No	Frequency
Do you drink alcohol?	____	____	______________
Do you smoke?	____	____	______________
Do you use recreational Drugs?	____	____	______________