

Urology Care, Inc. Patient History Form (Please Print)

Last Name: _____ First Name: _____ MI _____

Social Security No: _____ Date of Birth ____/____/____ Height _____ Weight _____

What is the main reason for your visit? (Describe your problem in detail) Today's Date: _____

Allergies and Medications

List your current allergies:

List all your current medications: (you may provide a list if available)

Provide the name, address and phone number of your preferred pharmacies.

Past Medical and Surgical History

List any personal illnesses/diagnosis/disease and when they occurred: Example (Bladder cancer, Diabetes)

List any procedures/surgeries you have had. Please provide approximate date of procedure/surgery:

Family History

Circle any illnesses in your immediate family: Include the relationship to you :

Prostate Problems _____ Bladder Cancer _____ Kidney Cancer _____ Breast Cancer _____
Diabetes _____ Heart Problems _____ High Blood Pressure _____ Uterine Cancer _____
Kidney Failure _____ Infertility _____ Lung Cancer _____ Skin Cancer _____ Tuberculosis _____
Parkinson's Disease _____ Kidney Stones _____ Thyroid Problems _____ Stroke _____

Other: _____
