

BRIEF HISTORY

In an effort to serve you better, Urological Care, Inc. request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last Name:	First:	Age:	Sex:
Presenting Problem or Proposed Surgery:			

ILLNESS / INJURY: Please check if you have ever had any of the following.							
YES		NO		YES		NO	
			High Blood Pressure				Kidney stones
			Diabetes				Abdominal Bleeding
			Peptic Ulcer				Diverticulosis
			Heart Attack				Thyroid
			Chest Pain / Tightness				Lung Problems
			Heart Murmur				Asthma
			Stroke				Shortness of Breath
			Cancer Type:				Cholesterol
			Hepatitis				Gout
			Yellow Jaundice				Congestive Heart Failure
			Gallstones				Broken Bones List:
			Sleep Apnea				

OPERATIONS: List names and dates of all operations you have had. <input type="checkbox"/> None		
	Year	Name of Operation
1		
2		
3		
4		
5		
6		

Have you ever had a blood transfusion? YES NO

List any hospital admissions or medical conditions not listed above:

Are you pregnant? YES NO

DRUGS: Please list all drugs you take and their dosages. <input type="checkbox"/> None			
Drug Name	Dosage	Drug Name	Dosage

ALLERGIES: Please list type and reaction.			
Name of Drug	Reaction	Name of Drug	Reaction

Do you now use tobacco?	YES	NO	How many per day?	_____	Years?	_____
Have you ever used tobacco?	YES	NO	Years quit?	_____		
Do you drink alcohol?	YES	NO	How many years?	_____		
Have you ever used alcohol?	YES	NO	How many years?	_____		

The above information is true and accurate.

PT SIGNATURE: _____ DATE: _____