UROLOGY SAN ANTONIO

Patient's Name: ____________________

DOB: __________ App't Date: __________

MEDICAL HISTORY

REV. 9/20/2011

Current Medications List all medications you currently take including vitamins, herbal supplements and over-the-counter medications. If needed, attach an additional sheet.

Medication	Indication	Dosage	Frequency You Take It	Start Date

Allergies List any medical or environmental allergies you have.

____________________ ☐ None

Labs & Imaging List any recent laboratory or imaging studies completed outside of our of office and where we can request the results, if needed.

____________________ ☐ None

Medical History Note any diseases or conditions you now have or have had in the past.

Cardiovascular: ☐ Atrial Fibrillation ☐ Heart Attack ☐ Stroke ☐ Deep Vein Thrombosis ☐ High Blood Pressure ☐ Congestive Heart Disease ☐ Transient Ischemic Attack (TIA)

Endocrine: ☐ Diabetes ☐ Gout ☐ Hyperthyroid ☐ Hypothyroid

General: ☐ Hepatitis ☐ Elevated Cholesterol ☐ HIV

Gastrointestinal: ☐ Crohn's Disease ☐ Diverticulitis ☐ Pancreatitis ☐ Inflam. Bowel Disease ☐ Ulcerative Colitis

Genitourinary: ☐ Bladder Cancer ☐ Enlarged Prostate ☐ Kidney Failure ☐ Hematuria (Blood in Urine) ☐ Bladder Leakage ☐ Kidney Cancer ☐ Kidney Stones ☐ Urinary Retention ☐ Elevated PSA ☐ Erectile Dysfunction ☐ Testicular Cancer ☐ Urinary Tract Infections ☐ Interstitial Cystitis ☐ Prostate Cancer ☐ Low Testosterone

Eyes, Ears: ☐ Blindness ☐ Cataracts ☐ Glaucoma ☐ Deafness

Rheumatology: ☐ Rheumatoid Arthritis ☐ Fibromyalgia ☐ Sjogren's Syndrom ☐ Lupus ☐ Immunosuppression

Neurological: ☐ Alzheimer's ☐ Bi-polor Disorder ☐ Depression ☐ Migraines ☐ Multiple Sclerosis ☐ Seizures ☐ Parkinson's

Respiratory: ☐ Asthma ☐ COPD ☐ Emphysema ☐ Tuberculosis ☐ Pulmonary Embolism

Cancer: ☐ Breast ☐ Colon ☐ Leukemia ☐ Lung ☐ Lymphoma ☐ Rectal ☐ Other ________

Cancer Treatment: ☐ Surgery ☐ Chemotherapy ☐ Radiation ☐ Other ________

List any other medical problems not noted above. ____________________

Surgical History
Note any surgies you have undergone.

Cardiovascular: ☐ Angioplasty ☐ Carotid Artery ☐ Heart Stents ☐ Coronary Artery Bypass ☐ Pacemaker ☐ Heart Valve Replacement

General/GI: ☐ Hernia Repair ☐ Appendectomy ☐ Colon Surgery ☐ Gallbladder Removal

Genitourinary: ☐ Urethral Stricture ☐ Prostate Biopsy ☐ Bladder Suspension ☐ Sound wave treatment of kidney stone (ESWL) ☐ Vasectomy ☐ Removal of Testis ☐ Surgery for Enlarged Prostate (TURP) ☐ Surgery on Kidney ☐ Surgery to Remove Kidney Date of procedure(s) ______

Orthopedic: ☐ Hip Replacement ☐ Knee Replacement ☐ Back Surgery ☐ Knee Scope ☐ Shoulder Surgery

Gynecological: ☐ Uterus Removed ☐ Ovaries Removed ☐ Tubal Ligation

__ No. Pregnancies __ No. Births __ No. Vaginal Delivery __ No. C-Sections __ Menopause Age

List any other surgeries and their dates. ______

Social History
Mark the answer that best describes you.

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated/Divorced ☐ Significant Other

Highest Education: ☐ High School ☐ Vocational/Trade ☐ College ☐ Graduate Degree

Job Status: ☐ Full Time ☐ Part-Time ☐ Student ☐ Retired ☐ Other ______

Alcohol Use: ☐ None ☐ Yes: Drinks Per Day ______ Week ______ Month ______

Smoking/Tobacco Use: ☐ None ☐ Ex-Tobacco User: Date Quit ______ ☐ Tobacco User: Packs/Units Per Day ______

Family History
Note the diseases and illnesses your biological family members have had.

Cancer:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Heart Disease:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
High Blood Pressure:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Stroke:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Diabetes:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Kidney Stones:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Enlarged Prostate:		☐ Father	☐ Brother		☐ Grandparent
Prostate Cancer:		☐ Father	☐ Brother		☐ Grandparent

Other family history not noted above: ______

Medical Symptoms
Mark any of the symptoms you are currently experiencing.

General:	☐ None	☐ Chills	☐ Fever	☐ Weight Loss	☐ Weight Gain
Eyes:	☐ None	☐ Blurred Vision	☐ Double Vision		
Experiencing Allergies:	☐ None	☐ To Medications	☐ To Food	☐ Seasonal	
Neurological:	☐ None	☐ Dizzy	☐ Headache		
Gastrointestinal:	☐ None	☐ Constipation	☐ Diarrhea	☐ Heartburn	
Muscles and Joints:	☐ None	☐ Arthritis	☐ Cramps	☐ Joint Pain	
Respiratory:	☐ None	☐ Shortness of Breath	☐ Wheezing	☐ Productive Cough	
Hematological	☐ None	☐ Anemia	☐ Bleeding	☐ Swollen Gland	