Texas Center for Urology

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Past Medical History

Last Name_____ First_____

DOS_____ DOB_____ Primary Care Physician_____

Reason for your visit today? _____

DRUG ALLERGIES

Are you allergic to any of the following medication? If not listed, please write the allergy.

___Penicillin ___Cipro ___IVP Dye
___Sulfa ___Levaquin ___Latex
___Aspirin ___Macrodantin ___Codeine/Opiates
___Blood Pressure Medication ___Cephalosporins
___Other_____

MEDICATIONS

Please list all current medications you are taking or attach a list.

NAME: EX…LISINOPRIL	DOSAGE: 10MG	FREQUENCY: ONCE DAILY

PHARMACY

Name: _____ Phone: _____

Address: _____

SURGICAL HISTORY

___Hysterectomy→___Abdominal___Vaginal→Do you have your ovaries? ___Y ___N
___Gallbladder ___Bladder Suspension ___Hemorrhoidectomy
___Appendectomy ___Prostate Surgery ___Tonsillectomy
___Colon Resection ___Heart Surgery ___Hernia Surgery
___Other Surgeries_____

MEDICAL HISTORY

Mark an X next to any of the following that **YOU** have now or had in the past.

___High Blood Pressure
___Diabetes/Insulin___/pills
___Heart Attack
___Irregular Heartbeat
___Prostate Cancer
___Kidney Cancer
___I.B.S.
___Depression
___Bladder Cancer
___Emphysema(COPD)
___Asthma
___T.B.
___Glaucoma
___HIV
___Venereal Disease
___High Cholesterol
___Anxiety Disorder
___Breast Cancer
___Colon Cancer
___Diverticulitis
___Thyroid Disease
___Hep C
___GERD
___Kidney Stones
___Mental Disorder

FAMILY MEDICAL HISTORY

Do any of your immediate family members have any of the following? Please indicate relationship to you.

	Grandmother	Grandfather	Mother	Father	Brother	Sister	Aunt	Uncle
Heart disease								
Diabetes								
Breast Cancer								
Colon Cancer								
Prostate Cancer								
Ovarian/Pancreatic Cancer								
Kidney Cancer								

SOCIAL HISTORY

Marital Status: _____ Language Spoken: _____
Occupation: _____ Employment Status: ___Full Time ___Part Time ___Retired

Tobacco Use: Yes / No, #packs/day ____ Number of years smoking _____
If you have stopped smoking, when did you stop ___/___/___?
Smokeless Tobacco Use: Yes / No

Alcohol Use: Yes / No, How often ___daily ___weekly ___monthly
___Beer ___Wine ___Liquor
How much do you drink at one time_____?

Do you use recreational drugs such as marijuana, etc? Yes / No How often? _____
Caffeine Use: Yes / No How much_____? Have you ever had a blood transfusion: Yes / No?

REVIEW OF SYSTEMS

Mark an X next to any of the following that YOU have now

Constitutional: ___ Fever, ___ Chill/Sweats, ___ Weight loss/gain

Eyes: ___ Blurry Vision, ___ Double Vision, ___ Cataracts

ENT: ___ Hearing Loss, ___ Nasal Stuffiness, ___ Sore Throat

Respiratory: ___ Shortness of Breath, ___ Wheezing, ___ Chronic Cough

Gastrointestinal: ___ Abdominal Pain, ___Nausea/Vomiting, ___ Change in Bowels

Genitourinary: ___ Incontinence, ___ Painful Urination, ___ Blood in Urine

Musculoskeletal: ___ Chronic Back Pain, ___ Chronic Neck Pain, ___ Sore Muscles

Integumentary /Skin: ___ Rash, ___ Persistent Itching, ___ Skin Cancer History

Neurological: ___ Numbness, ___ Tingling, ___ Dizziness

Hematologic /Lymphatic: ___ Swollen Glands, ___ Abnormal Bleeding, ___ Blood Transfusions