The Urology Center

PATIENT HISTORY FORM

NAME: _____ **AGE**:_____

Medical History:

Have you ever had: (circle yes or no)

Kidney Stones	Yes	No	Unusual bruising or bleeding	Yes	No
Kidney Failure	Yes	No	Stroke/CVA	Yes	No
High Blood Pressure	Yes	No	Arthritis	Yes	No
Diabetes	Yes	No	Bowel/Colon difficulty/disease	Yes	No
Gall Bladder Disease	Yes	No	If Yes, explain_____		
Urinary Tract Infection	Yes	No	_____		
Emphysema	Yes	No	Other:_____		
Heart Attack	Yes	No	_____		
Tobacco use?	Yes	No	Alcohol use?	Yes	No
If yes, how many packs per day?_____			If yes, how much?_____		

Allergies: (medication or other)

_____
_____
_____
_____
_____
_____
_____

Previous Surgeries:

_____
_____
_____
_____

Current Medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____