New Patient History

**Name**:_____ **Date**:_____

**REFERRING DOCTOR**: _____ Primary Doctor _____

Why are you seeing the doctor today? _____

Have you seen any prior urologists? _____

Current Medications (Or attach medication list)

Medication name:

_____ _____ _____ _____

_____ _____ _____ _____

**ALLERGIES**: _____

**PHARMACY NAME** _____ **ADDRESS or CROSS STREETS** _____

**FAMILY HISTORY (circle and indicate which family member)**

**Prostate cancer** **Kidney Cancer** **Kidney stones** **Other** _____

**SOCIAL HISTORY**

**Marital Status**: Married Single Divorced Widowed

**Occupation** _____ Retired _____

**Tobacco use** _____Never smoked _____ Current smoker _____Former smoker

**Recreational drugs** ____ none If yes, please list _____

**Alcohol** _____ drinks/day _____ former abuse _____ Socially _____ Never

Preferred Language _____

**SURGICAL HISTORY**

**List** _____

_____

**PAST MEDICAL HISTORY (circle)**

High blood pressure
Diabetes
Coronary Artery Disease (heart)
Heart Attack
Atrial arrythmia
Blood clot (DVT or PE)
Liver disease
Kidney Disease/ failure

Fibromyalgia
Asthma/ COPD
Diverticulosis/ Diverticulitis
Prior Radiation Treatment

Other _____
_____

New Patient History

**REVIEW OF SYMPTOMS**
**(circle if applies)**

**Constitutional**
Fevers
Chills

**Skin**
Rash
Bruising

**Cardiovascular**
Chest Pain
Heart Murmur

**Respiratory**
Cough
Shortness of Breath

**GI**
Nausea/vomiting
Diarrhea
Constipation

**Urology (GU)**
Pain with urination
Urinary frequency
Incontinence
Blood in urine

**Hematologic**
Anemia
Increased bruising

**Musculoskeletal**
Back pain
Muscle Weakness

**Neurological**
Seizure
Headache

**Psychologic**
Anxiety
Depression