UROLOGICAL ASSOCIATES OF THE PIEDMONT
PATIENT MEDICAL HISTORY

Name: ____ Date: ______________________
Age: ______ Date of Birth: ______________________ Place of Birth: ____
Marital Status: __ Single __ Married __ Divorced __ Widowed Account #: _____________________________________
Present or Former Occupation: ____
Referring Physician (name, address and phone number): ____
Primary Care Physician (name, address and phone number): ____
____
Patient Ethnicity: ____________ Patient Race: ____________ Patient Language: ____________ Declined: ___________
Local Pharmacy of Choice and Location: ____
Mail Order Pharmacy of Choice: ____

PAST MEDICAL HISTORY

Do any of these Medical Problems below apply to you? Please check all that apply.

☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Liver Problems
☐ Anxiety	☐ Dizziness	☐ Shortness of Breath	☐ Bone or Joint Disease
☐ Arthritis	☐ Emphysema	☐ Irregular or Fast Heartbeat	☐ Epilepsy
☐ Bleeding Tendency	☐ Headaches	☐ Seizures	☐ Heart Disease
☐ Blood Clots	☐ Hearing Loss	☐ HIV	☐ Colitis
☐ Cancer	☐ MRSA	☐ Sleep Apnea	☐ Chrohn's Disease
☐ Chronic Leg Swelling	☐ Heart Attack	☐ Stomach Ulcers	☐ Weight Loss
☐ Tuberculosis	☐ Heartburn/Reflux	☐ Stroke	☐ Other:
☐ Chest Pain	☐ Hepatitis	☐ Thyroid Disease	
☐ Depression	☐ High Cholesterol	☐ Asthma	

PAST SURGICAL HISTORY

Please list **ALL** of your previous Surgeries.

Date	Type of Surgery

FAMILY MEDICAL HISTORY

Mother: Alive __ Deceased __ If Deceased, cause of death: ____
Father: Alive __ Deceased __ If Deceased, cause of death: ____

Do you have any 1st degree relatives with **Urological Disorders**?

Relative	Urological Disorder

SOCIAL HISTORY

Do you currently smoke? Yes __ No__ If yes, daily usage: ______________________ Number of Years: ____________
If no, have you ever smoked? Yes __ No __
Do you drink alcohol? Yes __ No__ Socially__ If yes, how many drinks per day? _________________________________
Have you had any alcohol or drug dependency problems? Yes __ No__

ALLERGY

Are you **ALLERGIC** to any **MEDICATIONS**? No __ Yes__ If yes, please list: ____

____

Other Allergies: No __Yes __ Metal __ Iodine __ Shellfish __ Latex__

Other: ____

Have you had any unusual reaction to anesthesia? No __ Yes __ (type of reactions): ______________________________

____

MEDICATION HISTORY

Please list **ALL** Medications you are presently taking. (As well as over the counter, herbs, supplements)

Medication	Dosage	Frequency

Signed By: ____

Patient/Guardian Signature

REVIEWED BY:

(Office Use Only)

Date	Name	Date	Name