Urology Experts

Note: This is a confidential record and will be kept at your doctor's office

Name _____ **Todays Date** / /

AGE _____ **DOB** / / **Referring Physician** _____

LIST ALL MEDICAL AND SURGICAL HISTORY (Date of Onset)

1
2
3
4
5
6
7
8
9
10

CURRENT MEDICATIONS (dosage/strength - including asprin)

1
2
3
4
5
6
7
8

ALLERGIES

A
B
C
D
E
F
G
H
I

FAMILY HISTORY (List any diseases of Immediate Family Members)

1 3
2 4

FAMILY HISTORY OF PROSTATE CANCER **NO** **YES/**

What relation Is that family member to you?

Mother **Alive** **Deceased** **Age** **From What?**

Father **Alive** **Deceased** **Age** **From What?**

Social History: **Do you Smoke?** **Yes** **No** **How Much**

Did you quit smoking, if yes when? **How many years of smoking?**

ALCOHOL **YES** **NO** **HOW MUCH** **# OF YEARS**

Primary Phone # **Name of pharmacy and Phone #**

Occupation (what do you or did you do for a living?

Where are you from originally?

What is the main Reason for your visit today?