

encore UROLOGY

Medical History

Date: _____

Patient Full Name: _____ Age: _____

Medical History:

Do you currently suffer from any of the following (check all those that apply)?

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Bleeding Problems | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Cataracts of the Eyes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other: _____ |

Past Surgical History:

Please check the surgical procedures which you have had done in the past.

- | | | |
|---|---|--|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Bladder Surgery | <input type="checkbox"/> Open Heart Surgery |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gall Bladder Removal | <input type="checkbox"/> Pacemaker Implanted |
| <input type="checkbox"/> Artificial Joint Implant | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Open Heart Surgery |

Allergies:

Please check any medications to which you are allergic.

- | | | |
|--|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Codeine | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Compazine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Blood Pressure Medication | <input type="checkbox"/> Hydrocodone | <input type="checkbox"/> Phenergan |

Family Medical History:

Please check the boxes of any diseases which may run in your family.

- | | | |
|---|--|--|
| <input type="checkbox"/> Aneurysms | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> Kidney Cancer | <input type="checkbox"/> Prostate Cancer |

Social History:

Do you smoke? Yes No

If yes, how many packs per day? _____

If no, did you ever smoke? Yes No

If you no longer smoke, but indicated that at one time you did smoke, when did you quit (year)? _____

Do you consume alcoholic beverages? Yes No

If yes, how many drinks per day (on average)? _____

If no, did you ever drink? Yes No

If you no longer drink alcohol, but indicated that at one time you did, when did you quit (year)? _____

Occupational History:

Please check the box that currently applies. If you are currently working, please include your job title.

Retired

Currently Working: _____

Medications:

Please list all current medications you take (you do not have to list what you take it for). If you do not know the names of your medications, just check the box 'Do Not Know'.

Do Not Know

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____