

encore UROLOGY

Personal History

Date: _____

Patient Full Name: _____ Age: _____

Party responsible for providing this information: _____

Party responsible for providing transportation: _____

Physical/Sensory Limitations or Restrictions: _____

Check all that apply: Glasses Contacts Dentures Loose Teeth Capped Teeth
 Broken Teeth Missing Teeth Hearing Aid/Hearing Deficit

Have you had prior surgery or a major illness within last 5 years?: Yes No

Have you had any anesthesia? Yes No If yes, please list dates: _____

Have you or anyone in your family ever had an unusual reaction to anesthesia? Yes No

If so, what was the reaction? _____

Do you have any implants? Knee Hip Pacemaker Other: _____

Do you drink alcohol? Yes No Occasionally

If yes, what kind: _____ How many drinks per week?: _____

Do you use tobacco? Yes No If yes, number of years used: ____ or year quit: ____

If yes, what kind? Cigarettes: Pks./day ____ Chew: #/day ____ Pipe: #/day ____ Cigars: #/day ____

Are you on a special diet? Yes No

WOMEN: Are you pregnant? Yes No LMP: _____

Do you lead a lifestyle that puts you at risk for HIV or Hepatitis B? Yes No

Last Physical Exam: Date: _____

Physician: _____

STAFF USE ONLY

Physician Name: _____ Cardiac clearance: Yes No

Vitals: Height: _____ Weight: _____ Resp. Rate: _____ Temp: _____ BP: _____ Pulse: _____

Diagnosis: _____

Procedure Date: _____ Post Op Date: _____