

MEDICAL HISTORY

PATIENT NAME: _____ DOB _____ DATE: _____

UROLOGY PHYSICIAN NAME: _____ REFERRING DOCTOR: _____

PROBLEM/CHIEF COMPLAINT: _____

Medications: (name and dosage)

1. _____
2. _____
3. _____
4. _____
5. _____

(Medication) Allergies: _____

Medical History:

	Yes	No		Yes	No		Yes	No
Abnormal Pap			Diabetes mellitus			Liver disease		
Asthma			HIV/AIDS			Stroke		
Clotting Disorder			Hormone problems			Thyroid disease		
Colitis/bowel disease			Hypertension			Ulcers		
Colon polyps			Infertility			Urinary tract infection		
COPD			Kidney Disease					

Family History

COMMENTS:

<u>GI</u>	Yes	No
Abnormal Distention		
Abnormal Pain		
Anal Bleeding		
Blood in stool		
Constipation		
Diarrhea		

