The Urology Clinic Intake

Appointment Date: _____
Name: _____ Birth date: _____
Height: _____ Weight: _____
Primary Care Physician: _____ Pharmacy: _____
Why are you seeing the Urologist today? _____

List all allergies:

_____ _____ _____
_____ _____ _____

List all medications/vitamins and dosages:
Please remember to bring the actual bottles with you.

_____ _____ _____
_____ _____ _____
_____ _____ _____

List all previous surgeries:

_____ _____ _____
_____ _____ _____

Have you ever had a colonoscopy? _____ If yes, when? _____
Have you had a pneumonia vaccine? _____ If yes, when? _____

List all medical problems:

_____ _____ _____
_____ _____ _____

List all medical problems that run in your family and your relation to them:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Does anyone in your family have prostate cancer? _____, If yes, who? _____

Do you smoke? _____ Do you use smokeless tobacco? _____ E cigarette? _____
How much? _____ Did you quit? _____ When? _____
How long did you smoke or use smokeless tobacco? _____

How much caffeine do you use per day? _____
Do you drink alcohol? ____ How much per week? _____ For how long? _____
Do you use recreational drugs? _____ If yes, what type _____

What is your occupation: _____?
What ethnicity are you? Caucasian African American Hispanic Other

Are you <u>currently</u> experiencing any of the following symptoms? (Circle all that apply):

Kidney stones	Urinary tract infections	Blood in urine	Painful urination
Fever	Chills	Blurry vision	Double vision
Nasal stuffiness	Sore throat	Chest pain	Swelling
Shortness of breath	Wheezing	Back pain	Bone pain
Rash	Itching	Numbness	Dizziness
Swollen glands	Abnormal bleeding	Nausea/vomiting	Abdominal pain
Blood in your stool			