Urology Associates of Norwalk, PC Medical History Form

What is the reason for your visit today? _____

If you (the patient) do not circle or list the items below when asked, it will be assumed your answer is "NO" or "NONE"

Have you had any of the following relevant to your urology visit today? (**circle if YES**):
Bloodwork, X-rays, CT scan, MRI, ultrasound

Your Name and mailing address: _____

_____

Your best phone contact numbers: _____

_____

Emergency contact name and phone number: _____

Your Referring or Primary Doctor: _____

Your Pharmacy name/location: _____

Do you have **allergies** to any of the following (**circle if yes**)?:
Aspirin, NSAIDS (such as ibuprofen/advil), Penicillin, Sulfa, Iodine, Cipro, Latex,
Other: _____

Height and Weight _____ Do you drink alcohol? If so, how much?_____

Do you smoke? _____ Do you drink alcohol? If so, how much?_____

Are you pregnant or nursing? _____

If you have a **family history** of any of the following, **please circle if yes:**
prostate cancer, heart disease, hypertension, asthma, kidney failure, kidney stones, stroke, diabetes, bleeding disorder, other cancers.

If **you** the patient have had any of the following conditions, **please circle if yes:**
Abnormal heart rhythm, high cholesterol or lipids, heart disease, chest pain, heart attack, high blood pressure, congestive heart failure, heart valve problems, vascular disease, lung or breathing problems, emphysema, asthma, pneumonia, sleep apnea, home oxygen use, tuberculosis, kidney problems, kidney failure, kidney stones, liver problems, hepatitis, jaundice, seizures, stroke, TIA, neuropathy, migraines, acid reflux or heartburn, stomach ulcers, hiatal hernia of the stomach, diabetes, thyroid disease, anemia, bleeding or clotting disorder, HIV or AIDS, depression, anxiety, bipolar disorder, panic attacks, schizophrenia, Other: _____

List ALL of your current medications:

List ALL of your prior surgeries:

To the best of my knowledge, the questions on this form have been accurately and completely answered. I understand that providing incorrect or incomplete information can be dangerous to my (or patients) health. It is my responsibility to inform my doctor of ANY changes in my medical history.

Patient Name: _____

Patient Signature: _____ Date: _____