Urology Associates of Norwalk, PC

MEDICAL HISTORY FORM

place label here

REASON FOR VISIT (check all that apply)					
Prostate		Renal Mass/Cyst		Kidney Stones	
Blood in Urine		Incontinence		ED	
Other:					

Have you had any the following recently?					
Blood work		X-rays		CT Scans	
If yes, where and when?					

Best number to call with lab/test results:		
Cell:	**Home:**	**Work:**

EMERGENCY CONTACT INFORMATION	**MARITAL STATUS: (circle one): M S D W**
Name:	**Number:**

PRIMARY / REFERRING PHYSICIAN NAME:	
Telephone:	**Fax:**

PHARMACY NAME::
ADDRESS:

ALLERGIES (check all that apply)		**NONE:**			
Aspirin		Penicillin		Sulfa	
Codeine		Iodine		Latex	
Other:					

LIST ANY PREVIOUS SURGERIES	**LIST ALL MEDICATIONS CURRENTLY TAKING**

PERSONAL					
Do you use tobacco?	Yes	No	Do you drink alcohol?	Yes	No
If yes, how much?			If yes, how much		
Are you pregnant?			Due Date?		
Are you nursing?					
Height:			Weight:		

FAMILY HISTORY					
	Yes	No		Yes	No
Heart Disease			Bleeding Disorders		
High Blood Pressure			Prostate Cancer		
Asthma			Lung Cancer		
Kidney Failure			Breast Cancer		
Stroke			Colon Cancer		
Diabetes			Ovarian Cancer		

Patient Signature: _____ Date: _____

Patient REVIEW OF SYSTEMS

CARDIAC	Yes	No
Abnormal Heart rhythm		
High Cholesterol of lipids		
Coronary Artery Disease		
Heart related chest pains		
Heart Attack		

	Yes	No
High Blood Pressure		
Congestive Heart Failure		
Heart Valve Problems		
Vascular disease (low blood flow)		
Other:		

PULMONARY	Yes	No
Emphysema		
Asthma		
Pneumonia with last 6 weeks		
Diagnosed with Sleep Apnea		
Home Oxygen Use		
Tuberculosis		
Other:		

RENAL (kidney)	Yes	No
Kidney Failure		
Kidney Stones		
Urinary Incontinence		
Other:		

HEPATIC (liver)	Yes	No
Liver failure		
Jaundice		
Hepatitis		
Other:		

NEUROLOGIC (nervous system)	Yes	No
Seizures		
Stroke (including mini strokes)		
TIA		
Neuropathy		
Migraines		
Other:		

GI (stomach and intestines)	Yes	No
Frequent acid reflux or heartburn)		
Stomach Ulcers		
Hiatal Hernia of the stomach		
Other:		

ENDOCRINE (glands)	Yes	No
Insulin dependent diabetes		
Non-insulin dependent diabetes		
Thyroid disease		
Low		
High		
Other:		

HEMATOLOGIC (blood)	Yes	No
Anemia		
Recent use of blood thinners		
Bleeding or clotting disorder		
HIV or AIDS		
Other:		

PSYCHIATRIC	Yes	No
Depression		
Bipolar disorder		
Panic/anxiety attacks		
Schizophrenia		
Other:		

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

I authorize that payment of insurance benefits be made to The Urology Associates of Norwalk, PC of services rendered for me. I authorize any medical information about me be released to my insurance company or its agents as needed to determine benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any fees in collection of unpaid amounts. I allow the office to bill electronically with my signature on file in the office.

Patient signature: _____ Date: _____