Illinois Urological Institute, S.C.

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MEDICAL HISTORY

NAME:_____ DATE: _____

BIRTHDATE: _____ AGE: _____ HT: _____ WT: _____

PRIMARY PHYSICIAN: _____ DR. PHONE #: _____

REFERRED BY: _____ MARITAL STATUS:_____

CARDIOLOGIST: _____ PHONE #: _____

PHARMACY: _____LOCATION/ADDRESS:_____ PHONE: _____

DO YOU HAVE A CARDIAC PACEMAKER? ----------	YES	NO
DO YOU HAVE ANY MEDICAL CONDITIONS THAT REQUIRE ANTIBIOTIC COVERAGE FOR SURGERY OR DENTAL WORK (i.e. heart valve, hip or knee replacement, other)? ----------	YES	NO
ARE YOU ALLERGIC TO INTRAVENOUS CONTRAST (iodine dye for xrays) OR SHELL FISH? ----------	YES	NO
DO YOU HAVE A LATEX ALLERGY? ----------	YES	NO
DO YOU TAKE BLOOD THINNERS (Coumadin, Plavix, Dypiridamole, etc.)? ----------	YES	NO
DO YOU TAKE ASPIRIN? ----------	YES	NO
ANY HISTORY OF RADIATION TREATMENTS? ----------	YES	NO
IS THERE ANY POSSIBILITY YOU COULD BE PREGNANT? ----------	YES	NO
FAMILY HISTORY OF PROSTATE CANCER? ----------	YES	NO
FAMILY HISTORY OF KIDNEY STONES? ----------	YES	NO
DO YOU CURRENTLY SMOKE? ----------	YES	NO
HAVE YOU USED TOBACCO PRODUCTS OR SMOKED IN THE PAST? ----------	YES	NO

PLEASE LIST ALL ALLERGIES TO MEDICATIONS: _____

PLEASE LIST CURRENT MEDICATIONS AND SUPPLEMENTS, DOSE, AND WHAT IT IS FOR:

Medication or Supplement / Dose / Reason for Medication | **Medication or Supplements/ Dose / Reason for Medication**

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

Medical Conditions (Circle): dementia diabetes gout heart disease kidney stones
Parkinson's sleep apnea stroke tuberculosis urine infection
cancer of prostate / bladder / kidney other: _____

Previous Surgery: _____

_____

Urology Symptoms (Circle): impotence urgent urination blood in urine (ever) incontinence (leaking of urine)
frequent urine painful urination night time urination slow stream
enlarged prostate other: _____

General Symptoms (Circle): fever nausea skin lesions shortness of breath
easy bleeding chest pain lack of interest in sex dizziness sleep problems

FOR MALE PATIENTS- LIST PSA LEVELS AND DATES (**P**rostate **S**pecific **A**ntigen): _____

WHAT IS THE MAIN CONCERN YOU WOULD LIKE TO HAVE ADDRESSED BY THE DOCTOR? _

_____