

EASTERN CONNECTICUT UROLOGY
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NAME: _____ DATE: ___ / ___ / 20__

PATIENT HISTORY

Requesting/ Primary Doctor _____

What is the reason or condition that brings you to our office?

List all of your medical conditions (i.e. diabetes, heart attack, hypertension, stroke, etc).

List all prior surgeries (include date, facility and surgeon):

List all medications and dose (aspirin products, herbal, prescription, over the counter, vitamins, etc).

Allergies to medications?	Y N =>	Please list: _____
Allergies to IV dyes/x-ray contrast?	Y N =>	Shellfish or iodine? Y N
Do you smoke tobacco products?	Y N =>	Packs per day x years: _____
Are you an ex-smoker?	Y N =>	Packs per day x years: _____
Do you drink alcohol?	Y N =>	Quantity per week: _____
Occupation: _____		Marital Status: S M D W

Significant family medical history? _____

Do you require antibiotic prophylaxis prior to medical/dental procedures? Y N

If so, list the medical condition(s): _____

Family history of kidney disease? Y N => Kidney stones? Y N

Family history of prostate cancer? Y N => Bladder cancer? Y N

Date of last menstrual cycle: ___ / ___ / _____ Number of pregnancies: _____

Number of vaginal deliveries: _____ Cesarean sections: _____

2 of 2 sheets