



# Urologic Consultants

of Southeastern Pennsylvania

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

**DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

	YES	NO		YES	NO
High Blood Pressure	___	___	Diabetes	___	___
Heart Problems	___	___	Stomach Disorders	___	___
Heart Murmur	___	___	Hepatitis	___	___
Angina	___	___	Phlebitis	___	___
Kidney Problems	___	___	Gout	___	___
Liver Problems	___	___	Blood Transfusions	___	___
Lung Problems	___	___	Seizures or Epilepsy	___	___
Asthma	___	___	Back Problems	___	___
Emphysema	___	___	Shellfish Allergy	___	___

**PLEASE LIST ANY OTHER PRESENT OR PAST MEDICAL PROBLEM NOT SHOWN ABOVE:**

\_\_\_\_\_

\_\_\_\_\_

**PLEASE LIST ANY PREVIOUS HOSPITALIZATIONS OR SURGERIES, INCLUDING THE YEAR:**

\_\_\_\_\_

\_\_\_\_\_

**PLEASE LIST ANY MEDICATIONS YOU ARE TAKING, INCLUDING THE DOSAGE OF EACH:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE LIST ANY ALLERGIES YOU MAY HAVE:** \_\_\_\_\_

\_\_\_\_\_

	YES	NO	IF YES, HOW MUCH:
<b>DO YOU SMOKE?</b>	___	___	_____
<b>DO YOU DRINK ALCOHOL?</b>	___	___	_____

**SIGNATURE OF PERSON COMPLETING FORM:** \_\_\_\_\_