PATIENT INFORMATION SHEET

Name:_____ Age:_____ Date:_____

LIST PRESCRIPTION MEDICATIONS

1, _____

2. _____

3. _____

4. _____

OVER THE COUNTER MEDICATIONS

1. _____

2. _____

3. _____

4. _____

Name of any drugs you are ALLERGIC to:_____

_____

Please list any SURGERY OR HOSPITALIZATIONS since your last visit:

_____

_____

Have you been diagnosed with any SERIOUS ILLNESSES since your last visit?
(such as, diabetes, cardiovascular, stroke, etc,)_____

_____

_____

Name of Family Doctor/Internist: _____

Pharmacy Name: _____

Pharmacy Phone: _____

What UROLOGICAL SYMPTOMS are you currently having?_____

_____

_____

_____

REVIEW OF SYSTEMS

Please circle all symptoms that you have experienced since your last visit with our office:

CONSTITUTIONAL:	Fever	Chills	Weight Loss
EYES:	Blurry Vision	Double Vision	Cataracts
EARS, NOSE, MOUTH THROAT:	Hearing Loss	Nasal Stuffiness	Sore Throat
CARDIOVASCULAR:	Chest Pains	Swollen Ankles	Irregular Heartbeat
RESPIRATORY:	Shortness of Breath	Wheezing	Chronic Cough
GASTROINTESTINAL:	Abdominal Pain	Nausea/Vomiting	Change in Bowels
GENITOURINARY:	Incontinence	Painful Urination	Blood in Urine
MUSCULOSKELETAL:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles
INTEGUMENTARY/SKIN:	Rash	Persistent Itching	Skin Cancer History
NEUROLOGICAL:	Numbness	Tingling	Dizziness
HEMATOLOGIC:	Swollen Glands	Abnormal Bleeding	Transfusion History

NONE OF THE ABOVE