LAKESHORE UROLOGY

New Patient History Form

Patient Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____

MEDICATION & ALLERGY LIST

Allergies: ☐ None ☐ Codeine ☐ IV Contrast ☐ Latex ☐ Penicillin ☐ Sulfa Drugs

Other Allergies: _____

Pharmacy Name & Address: _____

Pharmacy Phone & Fax Numbers: _____

Date	Please List Current Medications *(Include Frequent Over-The-Counter Drugs)*	Dosage	Frequency	Notes

PAST MEDICAL PROBLEMS *(Check All That Apply)*

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer; Type _____
- ☐ Recurrent UTIs
- ☐ Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes - # of years _____
- ☐ Diverticulitis
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Neurologic Disease _____
- ☐ Osteoporosis
- ☐ Peripheral Vascular Dis.
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Valvular Heart Disease

Other: _____

PAST SURGICAL HISTORY *(Check All That Apply)*

	Date		Date
☐ Appendectomy	_____	☐ Kidney Surgery	_____
☐ Back Surgery	_____	☐ Kidney stone surgery	_____
☐ Colon Surgery	_____	☐ Prostate surgery	_____
☐ Gastric Bypass	_____	☐ Bladder surgery	_____
☐ Gallbladder	_____	☐ Bladder Lift	_____
☐ Hernia Repair	_____	☐ Urethral Sling	_____
☐ Heart Stent	_____	☐ Other _____	
☐ Heart Bypass	_____		

FAMILY HISTORY *(Check All That Apply)*

	Father	Mother	Brother	Sister	Son	Daughter	Family
Enlarged Prostate							
Kidney Stones							
Prostate Cancer							
Kidney Cancer							
Bladder Cancer							
Other							

SOCIAL HISTORY *(Check All That Apply)*

Tobacco Use: ☐ Current ☐ Former ☐ Never / # of Packs Per Day: _____ Years Smoked: _____ Year Quit: _____

Caffeine: ☐ / ☐ Type: _____ / _____ Amount of Caffeine Per Day: _____

Alcohol: ☐ / ☐ Type: _____ #Drinks Per Week: _____