MidLantic UROLOGY

Date_____

Name_____ Birthdate_____ Age_____

Height_____ Weight_____

Marital Status: Single Married Divorced Widowed Separated

Reason for today's visit_____

Do you require antibiotics for dental procedures? Yes No

Allergies_____

Past Medical History (circle all that apply)

Diabetes	*High blood pressure*	*Heart attack*	*Stroke*
Pacemaker	*Bleeding problems*	*Cancer_____*	*Heart issues*
Lung (asthma)	*Emphysema*	*Liver disease*	*Kidney disease*
Nervous system (seizures etc)		*Immune system problems*	

*Other*_____

Last colonoscopy_____ Last flu shot_____ Last pneumonia shot_____

Family History

Father_____ Mother_____

Children_____ Siblings_____

Surgeries_____

Do you drink alcohol? Yes No Do you smoke? Yes No

Caffeinated beverages daily_____

FEMALE: Do you have urinary incontinence? Yes No

MALE: Have you had a PSA? Yes No Date_____ Result_____