

ADULT PEDIATRIC UROLOGY



Rev.Feb.05

PATIENT INFORMATION RECORD

Name _____ Social Security Number _____

Reason for visit _____

Referring Physician _____

Family Physician _____

Please list any major illnesses and/or any prior hospital stays you have had:

List any medication or pills taken regularly:

1.) _____

1.) _____

2.) _____

2.) _____

3.) _____

3.) _____

Recent bladder or kidney x-rays (when and where) _____

Please list medication to which you are allergic:

Please list any surgery you have had:

1.) _____

1.) _____

2.) _____

2.) _____

3.) _____

3.) _____

Have you ever had jaundice, hepatitis, or blood transfusions? _____ When? _____

Have you ever smoked? _____ If so, when? _____ How much? _____

Have you ever had heart trouble? _____ Have you ever had lung trouble? _____

Height _____ ft. _____ in. Weight _____ lb.

Family Medical History

	Heart Problems (please describe)	Cancer (please describe)	Other Major Problems
Mother			
Father			
Sister			
Brother			

Signature _____

Date: _____