ADULT PEDIATRIC UROLOGY

Patient Information Record

Name: Social Security #:

Reason for visit: Obstetrician/Gynecologist:

Referring Physician: Primary Care Physician:

Chronic or Major Illnesses (high blood pressure, asthma, heart problems, etc.)

Medications (please list)

Herbal Supplements

Allergies to medications

Past Surgeries

Date of last menstrual period Do you have regular periods? Y N

Have you been through menopause? Y N If so, have you had any vaginal bleeding after menopause? Y N

Have you experienced any abnormal vaginal bleeding (bleeding between periods or very heavy bleeding)? Y N

If so, please explain:

Do you have spotting or bleeding after intercourse? Y N

How many pregnancies have you had? How many miscarriages?

Please list births and specify mode of delivery (vaginal or c-section) and weights of babies

Your occupation

Marital Status (single, married, divorced, separated, widowed?)

Have you ever smoked cigarettes? If so, when and how many per day?

Do you drink alcohol? If so, how many drinks per week?

Do you use any recreational drugs? If so, what type?

Do any of these diseases, or any other major diseases, run in your family? If so, who has/had them?

Heart Problems Cancer (what kind)

Bleeding Disorders Kidney Stones