UROLOGY ASSOCIATES, LTD.
202 E. Earll Dr., Suite 360
Phoenix, Arizona 85012
Phone: (602) 264-4431

Visit Date:____________________ Doctor: ______________________________________

Patient Name: ______________________________________ Age: ____________ Birth Date: ________________________________

Address: ____

Home Phone: _____________________________ Work Phone: _________________________ Cell Phone: __________________

May we leave messages for you on your home answering machine? ☐ No ☐ Yes

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HEALTHCARE PROVIDER INFORMATION & AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Do you have a regular physician? ☐ No ☐ Yes→ Name: ____________________ Phone: ( ) _______________________

Address: ____

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MEDICATIONS

Are you currently taking any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, and cold medications?

☐ No ☐ Yes→ List medications below:

Name of Medication	Dose	How Often Taken

Have you taken aspirin-containing products in the last 2 weeks? ☐ No ☐ Yes

Have you taken steroid or cortisone-type drugs within the last year? ☐ No ☐ Yes

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ALLERGIES

Have you had hives, skin rash, breathing problems or other allergic reactions to medications?

☐ No ☐ Yes→ Please list below:

Name of Medicine	Describe Allergic Reaction

CONTINUED

SYSTEMS REVIEW

Have you experienced any of the following problems recently? **CIRCLE** Yes or No. Describe below.

CONSTITUTIONAL SYMPTOMS			SIGHT/SOUND			EAR/NOSE/THROAT/MOUTH		
Fever	Y	N	Blurry vision	Y	N	Ear infection	Y	N
Chills	Y	N	Glaucoma	Y	N	Sore throat	Y	N
Headaches	Y	N	Loss of hearing/Ringing	Y	N	Difficulty swallowing	Y	N
INTEGUMENTARY			**PULMONARY**			**CIRCULATORY**		
Skin rash	Y	N	Wheezing	Y	N	Chest pain	V	N
Boils	Y	N	Frequent cough	Y	N	High blood pressure	Y	N
Persistent rash	Y	N	Shortness of breath	Y	N	Varicose veins	Y	N
GASTROINTESTINAL			**GENITOURINARY**			**NEUROLOGICAL**		
Hepatitis	Y	N	Kidney failure	Y	N	Dizziness	Y	N
Ulcer/reflux	Y	N	Kidney stone	Y	N	Migraine	Y	N
Constipation	Y	N	Urinary tract infection	Y	N	Multiple sclerosis	Y	N
			Erectile dysfunction	Y	N			
MUSCULOSKELETAL			**ENDOCRINE**			**HEMATOLOGIC/LYMPMATIC**		
Back pain/surgery	Y	N	Diabetes	Y	N	Lymph node swelling	Y	N
Muscle disorder	Y	N	Thyroid disease	Y	N	Bleeding disorder	Y	N
Joint disorder	Y	N	Parathyroid disease	Y	N	Immune disorder (HIV)	Y	N

DESCRIBE PROBLEMS: ____

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QUESTIONS TO BE ANSWERED BY FEMALE PATIENTS ONLY:

Might you be pregnant at this time? Y N

Date of onset of your last menstrual period: Month: __________ Day: _____ Year:

Number of: Pregnancies______________________Live Births:__________________Miscarriages/Abortions: _______________

Please place a check (√) in the appropriate box for each organ listed. Describe the problem and type of surgery. **CIRCLE** the appropriate choice when multiple choices are listed in a question.

	No Problem	Medical Problem	Surgery	Year(s) of Surgery	Describe
1.Eyes (cataracts, glaucoma)	☐	☐	☐		
2.Ears, nose, sinuses, or tonsils	☐	☐	☐		
3.Thyroid or parathyroid glands	☐	☐	☐		
4.Heart valves or abnormal heart rhythm	☐	☐	☐		
5.Coronary (heart) arteries (angina)	☐	☐	☐		
6.Arteries (aorta/carotid) or veins (clot problems)	☐	☐	☐		
7.Lungs	☐	☐	☐		
8.Esophagus or stomach (ulcer)	☐	☐	☐		
9.Bowel (small & large intestine) or appendix	☐	☐	☐		
10.Liver or gallbladder (including hepatitis)	☐	☐	☐		
11.Hernia	☐	☐	☐		

CONTINUED

	No Problem	Medical Problem	Surgery	Year(s) of Surgery	Describe
12.Lymph nodes or spleen	☐	☐	☐		
13.Kidneys or bladder	☐	☐	☐		
14.Bones, joints or muscles	☐	☐	☐		
15.Back, neck or spine	☐	☐	☐		
16.Brain	☐	☐	☐		
17.Skin	☐	☐	☐		
18.Breasts	☐	☐	☐		
19.Females: uterus, tubes, ovaries	☐	☐	☐		
20.Males: prostate, penis, testes, vasectomy	☐	☐	☐		

SOCIAL HISTORY

Current Occupation(s): ____

Previous Occupation(s)/Job(s): ____

Have you used any of the following substances?

Substance	Currently Use?	Previously Used?	Type/Amount Frequency	How Long? (Years)	If stopped, when? (Yr.)
Caffeine: coffee, tea, soda	☐No ☐Yes	☐No ☐Yes			
Tobacco	☐No ☐Yes	☐No ☐Yes			
Alcohol-beer, wine, liquor	☐No ☐Yes	☐No ☐Yes			
Recreational/Street drugs	☐No ☐Yes	☐No ☐Yes			

Current Spouse Information: ☐Not applicable ☐Alive (Age_______) ☐ Deceased

Health problems or cause of death: ____

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FAMILY HISTORY

Father: ☐ Alive (Age_____) ☐ Deceased (Age______) ☐ Unknown Cause of Death: _______________ ☐ Unknown

Mother: ☐ Alive (Age______) ☐ Deceased (Age ______) ☐ Unknown Cause of Death: _______________ ☐Unknown

	Number Alive	Approximate Age(s)	Number Deceased	Approximate Age(s) at Death	Cause(s) of Death/Health Problems	
Brothers:	________	________	________	________	________	☐Unknown
Sisters:	________	________	________	________	________	☐Unknown
Sons:	________	________	________	________	________	☐Unknown
Daughters:	________	________	________	________	________	☐Unknown