



MEDICAL BACKGROUND FORM

Welcome to our office. The following information will help us meet your needs. Please ask us for help if you have any questions.

Name: _____ Male Female Today's Date: _____
 Date of Birth: _____ / _____ / _____ Weight: _____ Height: _____
 How did you hear about Summit Urology? _____

PLEASE CHECK REASON FOR VISIT—ADULT

- | | |
|--|---|
| <input type="checkbox"/> No-Scalpel Vasectomy | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Prostate Nodule | <input type="checkbox"/> Stress Incontinence (loss of urine with cough or sneezing) |
| <input type="checkbox"/> Prostate Enlarged on Exam | <input type="checkbox"/> Cystocele (fullness in vaginal area) |
| <input type="checkbox"/> Testicle Pain | <input type="checkbox"/> Urge Incontinence (loss of urine prior to getting to bathroom) |
| <input type="checkbox"/> Elevated PSA—Prostate specific antigen (screening test for Prostate cancer) | <input type="checkbox"/> Urinary Urgency |
| <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Circumcision |
| <input type="checkbox"/> Pyelonephritis (kidney infection) | <input type="checkbox"/> Genital Condyloma (warts) |
| <input type="checkbox"/> Cystitis (bladder infection) | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Blood in Urine (hematuria) | |
| <input type="checkbox"/> Impotence (inability to have an erection) | |

Other: _____

PLEASE CHECK REASON FOR VISIT—PEDIATRIC (CHILDREN)

- | | |
|--|--|
| <input type="checkbox"/> Enlarged Scrotum | <input type="checkbox"/> Hernia or Hydrocele |
| <input type="checkbox"/> Undescended Testicle | <input type="checkbox"/> Urinary Infections |
| <input type="checkbox"/> Burning on Urination | <input type="checkbox"/> Enuresis (bedwetting) |
| <input type="checkbox"/> Urinary opening too small | <input type="checkbox"/> Circumcision |

Other: _____

HAVE YOU OR YOUR FAMILY MEMBERS HAD ANY OF THE FOLLOWING PROBLEMS?

	Self	Family	How were they related to you?
Prostate Cancer	_____	_____	_____
Bladder Cancer	_____	_____	_____
Kidney Cancer	_____	_____	_____
Kidney Stones	_____	_____	_____
Kidney Failure	_____	_____	_____

PERSONAL INFORMATION

- | | Yes | No | |
|--------------------------------------|--------------------------|--------------------------|---------------------------------------|
| Are you on a special diet? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, describe: _____ |
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, how many packs per day? _____ |
| Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, amount: _____ |
| Do you have a history of drug abuse? | <input type="checkbox"/> | <input type="checkbox"/> | |

Please complete other side of form

PAST MEDICAL HISTORY

Do you have or have you experienced any of the following?

High Blood Pressure
 Heart Disease/Heart Attack
 Irregular Heart Rhythm
 Breathing Difficulties/Asthma
 Emphysema
 Ulcers or Colon Problems
 Seizures or Epilepsy
 Diabetes

Artificial Joints
 Artificial Heart Valves
 Chronic Infections
 Bleeding Disorders
 Hepatitis
 Cancer (type) _____
 TB (Tuberculosis)
 Sleep Apnea/C-pap machine

Other Medical Problems: _____

Are you pregnant? Yes Due Date: ____/____/____ No
 Last menstrual period: ____/____/____ Not applicable
 Are you on blood thinners or aspirin therapy? Yes No

PLEASE LIST ANY SURGERIES YOU HAVE HAD

Name of Surgery	Approximate Date	Name of Surgery	Approximate Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you have had surgery in the past, please list any complications: _____

PLEASE LIST CURRENT MEDICATIONS

Name	Dose	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ANY DRUG ALLERGIES

None

HAVE YOU HAD ANY OF THE PROBLEMS LISTED BELOW?

Constitutional Symptoms:

Fever Y N
 Chills Y N
 Headache Y N

Eyes:

Blurred Vision Y N
 Double Vision Y N
 Pain Y N

Allergic:

Hay Fever Y N
 Drug Allergies Y N

Respiratory:

Wheezing Y N
 Cough Y N
 Difficulty Breathing Y N

Neurological:

Tremors Y N
 Dizzy Spells Y N
 Numbness Y N

Endocrine:

Excessive thirst Y N
 Too Hot/Cold Y N
 Fatigue Y N

Gastrointestinal:

Abdominal Pain Y N
 Nausea/Vomiting Y N
 Indigestion Y N

Lymphatic:

Swollen Glands Y N
 Clotting Problem Y N

Cardiovascular:

Chest Pain Y N
 Varicose Veins Y N

Integumentary:

Skin Rash Y N
 Boils Y N
 Itching Y N

Musculoskeletal:

Joint Pain Y N
 Back Pain Y N
 Neck Pain Y N

Psychological:

Depression Y N
 Insomnia Y N