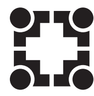 GRANGER MEDICAL CLINIC | *Summit Urology*

Your Name: ______________________ Age: ______ Date of Birth ______/______/______

Referring Physician ______________________ Family Physician ______________________

Pharmacy ______________ Phone ______________ Address ______________________

Your occupation ______________________________ Retired? Yes No

This information is now required by the Federal Government:
Primary Language ______________ Race ____________ Ethnicity ______________

CHIEF COMPLAINT:

What is the main reason for your visit today to the urologist? ______________________

____

____

____

List all of your current prescribed and over-the-counter medications (Please include Aspirin, vitamins, supplements, sinus/allergy medications, etc.):

Drug Name & Dose ______________________ Drug Name & Dose ______________________

Drug Name & Dose ______________________ Drug Name & Dose ______________________

Drug Name & Dose ______________________ Drug Name & Dose ______________________

Are you ALLERGIC to any medications? Yes No
If yes, Please list the medications you are allergic to: ______________________

____

LIST ALL SURGERIES/DATES:

Surgery: ______________ Date: __________ Surgery: ______________ Date: __________

Surgery: ______________ Date: __________ Surgery: ______________ Date: __________

Surgery: ______________ Date: __________ Surgery: ______________ Date: __________

Surgery: ______________ Date: __________ Surgery: ______________ Date: __________

MEDICAL HISTORY (circle the appropriate response in each column):

Do You Have a History of:				**Does your family have a history of:**			**Relationship to Patient**
Diabetes	Yes	No		Diabetes	Yes	No	__________
Heart Disease	Yes	No		Heart Disease	Yes	No	__________
Cancer	Yes	No	Type ______	Prostate Cancer	Yes	No	__________
High Blood Pressure	Yes	No		Bladder Cancer	Yes	No	__________
Kidney Stones	Yes	No		Kidney Cancer	Yes	No	__________
Stroke	Yes	No		Circulation Problems	Yes	No	__________
Bleeding Disorder	Yes	No	Type ______	Father Living?	Yes	No	
Breathing Problem	Yes	No	Type ______	Mother Living?	Yes	No	

Other Medical History ______________________

____

Cause of Death (Father) ______________________

Cause of Death (Mother) ______________________

Marital Status: (circle) Married | Single | Widowed	Have you ever smoked? (circle) Yes No
Number of children?______________	If yes, how long have you smoked?__________
	If yes, how long ago did you quit?__________
How many caffeinated drinks do you consume daily? 1 2 3 4+	Do you drink alcohol? Yes No longer Never
	If yes, do you drink: Daily Weekly Socially

Review of Body Systems

Please identify if you currently have problems related to the following systems:

Constitutional Symptoms:

Fever	Yes	No
Chills	Yes	No

Gastrointestinal Symptoms:

Abdominal Pain	Yes	No
Nausea/Vomiting	Yes	No
Indigestion	Yes	No

Cardiovascular Symptoms:

Chest Pain	Yes	No
Hypertension	Yes	No
Heart Attack	Yes	No
High Cholesterol	Yes	No
Pacemaker or Valve	Yes	No

Integumentary Symptoms:

Skin Rash	Yes	No
Persistent Itch	Yes	No
Boils	Yes	No

Endocrine Symptoms:

Unexplained Weight Loss	Yes	No
Excessive Thirst	Yes	No
Hot/Cold Spells	Yes	No

Respiratory Symptoms

Wheezing	Yes	No
Frequent Cough	Yes	No
Shortness of Breath	Yes	No

Hematologic/Lymphatic Symptoms:

Swollen Glands	Yes	No
Blood Clotting Problems	Yes	No

Genitourinary Symptoms:

Urine Retention	Yes	No
Painful Urination	Yes	No
Visible Blood in Urine	Yes	No
Urinary Frequency	Yes	No
Urinary Leakage	Yes	No

Neurological Symptoms:

Tremors	Yes	No
Difficulty Walking	Yes	No
History of Seizure Disorder	Yes	No

Musculoskeletal Symptoms:

Joint Pain	Yes	No
Neck Pain	Yes	No
Back Pain	Yes	No

Psychologic:

Do you have Anxiety?	Yes	No
Are you depressed?	Yes	No

Number of Pregnancies ____________

Number of Vaginal Deliveries ____________

Do you use Estrogen/Hormone Replacement? Yes No

Current PSA if known: ________ (Males Only)

Date drawn _____/______/_____

Lab/Physician where sample was drawn

____

Is there any additional information that you feel your physician should know?

____

____

Today's date ____/_____/____