

THE UROLOGY CENTER, P.C.
330 Orchard Street, Suite 164, New Haven, CT 06511
203-789-2222 Fax: 203-624-3697

ACCOUNT# _____

Name: _____ DOB _____ SS# _____

Address: _____ City: _____ St: _____ Zip: _____

Ref. Physician: _____ Marital Status: S M D W

Occupation: _____ No. of Children: _____

PATIENT HISTORY:

LIST ALL OF YOUR MEDICAL CONDITIONS (i.e. Hypertension, heart attack, diabetes, stroke, etc.)

LIST ALL PRIOR SURGERIES AND DATES:

LIST ALL MEDICATIONS AND DOSAGE (over the counter, aspirin products, prescription and herbal)

Allergies to medications? YES NO Please list _____

Allergies to IV dye or X-Ray Contrast? YES NO _____

Allergies to latex? YES NO Shellfish or iodine? YES NO _____

Do you use tobacco products? YES NO Please list _____ Years _____

Are an ex-smoker? YES NO Packs per Day _____ Years _____

Do you drink alcohol? YES NO Quantity _____

Do you require antibiotic prophylaxis prior to medical/dental procedures? YES NO

If yes, list the medical condition(s) _____

FAMILY MEDICAL HISTORY:

Significant family history? _____

Family History of Kidney Disease? YES NO Kidney Stones? YES NO

Family History of Prostate Cancer? YES NO Bladder Cancer? YES NO

GYNECOLOGICAL HISTORY:

Date of last menstrual cycle _____ Number of Pregnancies: _____

Number of Vaginal Deliveries _____ Cesarean Sections: _____