Urology Associates of Mississippi — Medical History Form

Name______________________________**DOB**_____________ **Occupation/Job**______________________________

Primary Doctor________________________________**Referring Doctor**_____________________________________

Doctors (Heart, Lung, etc.) ________________________**Pharmacy Name & Location**__________________________

Do you have any drug allergies? Y N please list ________________ _________________ _________________

What medicines do you take? ______________________ ____________________ ______________________

______________________ ______________________ _____________________ ______________________

______________________ ______________________ _____________________ ______________________

Do you take any blood thinners? (aspirin, plavix, coumadin etc.) Y N _________________________________

What surgeries have you had? ____

What medical problems do you have? Please circle: High blood pressure Diabetes High cholesterol

Heartburn Heart attack/Stent/Problems Stroke/TIA COPD/Lung problems Asthma HIV Hepatitis

Sleep Apnea Hypothyroid Arthritis Anemia Depression Anxiety Cancer (type) _____________

List any other medical problems: ____

What medical problems or cancers run in your family? ____

Marital Status: (please circle) Married Single Widowed Divorced Separated

Do you smoke? Y N **Did you ever smoke?** Y N **How much? Packs/day?** ________ **Years?** ____________

Do you drink alcohol? Y N **How much do you drink?** (please circle) Occasional 1 2 3 4 ≥5 /day

How many caffeinated drinks/day? 1 2 3 4 ≥5 /day **Have you ever had a blood transfusion?** Y N

Please review and circle those which apply to you: Fever Chills Headache Chest pain Easy fatigue

Irregular pulse Fainting Swelling (feet/ankles) Shortness of breath Wheezing Cough

Use inhaler Bloody phlegm Asthma Headaches Paralysis Seizures Head injury Dizziness

Tired/Sluggish Too Hot/Cold Excessive thirst Nausea/Vomiting Blood in stool Hemorrhoids

Diverticulosis Constipation/diarrhea Ulcer Frequent indigestion Incontinence Painful urination

Blood in Urine Arthritis Back pain Broken bones Bursitis Hard of hearing Frequent nose bleeds

Hoarseness Glaucoma Wear contacts Sinus problems Sore throat Cataracts Wear glasses

Blurred vision Rash Persistent itching Skin Cancer Swollen glands Abnormal bleeding

SIGNATURE____DATE______________________