

Diplomat American
Board of Urology

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Longmont Clinic
Urology

NAME _____ AGE _____ TODAY'S DATE _____

DATE OF BIRTH _____ WHO REFERRED TO OUR OFFICE? _____

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

PERSONAL HEALTH HISTORY (please include dates)

SURGERIES

ILLNESS/DISEASES

INJURIES

Do you have any other HEALTH CONCERNS not listed above? _____

List CURRENT MEDICATIONS (or attach list) _____

List MEDICATIONS ALLERGIES and/or ADVERSE REACTIONS _____

FAMILY HEALTH HISTORY

Current Age & State of Health

Age of Death & Cause

FATHER: _____

MOTHER: _____

BROTHERS: _____

SISTERS: _____

Do any other family members have cancer or serious illnesses? _____

MARITAL STATUS _____ OCCUPATION _____

DO YOU SMOKE? _____ IF YES, HOW MUCH? _____

HOW MUCH ALCOHOL DO YOU DRINK? _____

DO YOU NOW, OR HAVE YOU EVER, USED STREET DRUGS? _____