

ADVANCED UROLOGY ASSOCIATES

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Name _____ Date _____
 Date of Birth _____ Age _____
 Primary Care Physician _____
 Referral Source _____

<u>Allergies/Reactions</u>		Response
Name		
Contrast/Iodine Dye: Yes No		
1)		
2)		
3)		
4)		

<u>Non Prescription Medications and Herbal Supplements</u>		
Name	Dosage	Usage
1)		
2)		
3)		
4)		

Medication	Dosage	Usage	Medication	Dosage	Usage
1)			5)		
2)			6)		
3)			7)		
4)			8)		

Social/Lifestyle

Tobacco: ___ yes ___ no If yes, how much _____ #PPD _____ # years Year of discontinuation _____

Alcohol: ___ yes ___ no If yes, how many beverages _____

Recreational Drugs: ___ yes ___ no If yes, agents/usage _____

Marital Status: ___ single ___ married ___ widowed ___ divorced # children _____

Occupation: _____

Yes	No	<u>Medical History</u>
		Cardiac: myocardial infarction, angina, CHF, arrhythmia, mitral valve prolapsed, hypercholesterolemia
		Stress test _____ EKG _____
		Respiratory: asthma, bronchitis, COPD
		Neurological: headache, CVA, seizures
		Renal: chronic renal disease, acute renal disease
		Vascular: hypertension, peripheral vascular disease
		Musculoskeletal: arthritis, chronic back pain
		Gastrointestinal: ulcer disease, gastro-esophageal reflux
		Blood Disorders: anemia, hepatitis, blood clotting disorders, HIV
		Mental Health: depression, anxiety, dementia
		Endocrine: diabetes, hypothyroid
		Cancer:
		Other:
		Assistive Devices: glasses, contact lenses, dentures, partials, hearing aids

<u>Surgical History</u>	
Procedures	Year
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	

<u>Prior Urological History</u>			
Diagnosis	Year	Resolved	Ongoing
1)			
2)			
3)			
<u>Family Medical/Urological History</u>			
Diagnosis	Relationship		
1)			
2)			
3)			

