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: _____

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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
Number of children?_____

Have you ever smoked? (circle) Yes No
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 ____/_____/____