Southwest Premier Urology

UROLOGY HISTORY- Check **YES** if **current or past** medical problems or conditions exist					
Anxiety	Yes ☐	Hypertension	Yes ☐	Polycystic Kidney	Yes ☐
Asthma	Yes ☐	Interstitial Cystitis	Yes ☐	Pyelonephritis	Yes ☐
Bladder Cancer	Yes ☐	Kidney Disease	Yes ☐	Renal Cancer	Yes ☐
BPH	Yes ☐	Kidney Stone	Yes ☐	Sleep Apnea	Yes ☐
Cervical Cancer	Yes ☐	Low Testosterone	Yes ☐	STD	Yes ☐
Depression	Yes ☐	Myocardial Infarction	Yes ☐	Stroke	Yes ☐
Diabetes Mellitus	Yes ☐	Ovarian Cancer	Yes ☐	Urinary Incontinence	Yes ☐
Glaucoma	Yes ☐	Overactive Bladder	Yes ☐	Uterine Cancer	Yes ☐
High Cholesterol	Yes ☐	Peyronies Disease	Yes ☐	UTI	Yes ☐
Other Medical History:					

SURGICAL HISTORY- Check **YES** if Applicable					
Appendectomy	Yes ☐	Hernia Repair	Yes ☐	Oophorectomy	Yes ☐
Bladder Surgery	Yes ☐	Hysterectomy	Yes ☐	Small Intestine Surgery	Yes ☐
Cholecystectomy	Yes ☐	Joint Replacement	Yes ☐	Stone Surgery	Yes ☐
Colon Surgery	Yes ☐	Kidney Removal	Yes ☐	Testicle Removal	Yes ☐
C-Section	Yes ☐	Kidney Transplant	Yes ☐	Tubal Ligation	Yes ☐
Cystoscopy	Yes ☐	Lithotripsy	Yes ☐	Valve Replacement	Yes ☐
Other Surgical History:					

SOCIAL HISTORY

Alcohol Use- **Please Circle Your Response**

Glasses of wine per week	0	1	2	3	4	5	6	7	8	9	10 +
Glasses of beer per week	0	1	2	3	4	5	6	7	8	9	10 +
Shots of liquor per week	0	1	2	3	4	5	6	7	8	9	10 +

How often do you have a drink containing alcohol?	Never	Monthly	2-4 times a month	2-3 times a week	4 or more times a week
How many standard drinks containing alcohol do you have on a typical day?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or Almost Daily

Sexual Activity- Please Check your Response

Sexually Active?	☐ Currently	☐ Never	☐ Not Currently
Sexual partners	☐ Men	☐ Woman	☐ Both

Birth Control used?	☐ Condom	☐ Pulling Out	☐ Patch	☐ IUD
	☐ Implant	☐ Diaphragm	☐ The pill	☐ Other: _____

Drug Use- Please Check your Response

☐ None	☐ Marijuana	☐ Amphetamines	☐ Opioids	☐ Benzodiazepines	☐ Other: _____

Tobacco Use- Please Check you Response

Tobacco Use?	☐ Yes	☐ Never	☐ Passive	☐ Quit	Date Quit / /	Years Smoked:	Packs Per Day:
Smokeless Tobacco?	☐ Yes	☐ Never	Comment:				

First Name: _____ Last Name: _____ DOB:_____

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Family Medical History																
Relationship	Alive	Deceased	Anesthesia	Cancer	Clotting Disorder	Genitourinary	Heart Disease	Hypertension	Kidney Cancer	Malignant Cancer	Prostate Cancer	Lupus	Sudden Deathh	Urolithiasis	Asthma	Diabetes
Mother																
Father																
Sister																
Brother																
Maternal Aunt																
Maternal Uncle																
Paternal Aunt																
Paternal Uncle																
Maternal Grandmother																
Maternal Grandfather																
Paternal Grandmother																
Paternal Grandfather																

First Name: _____ Last Name: _____ DOB:_____