FAMILY DR: _____ **DATE:** _____

NAME: _____ **DATE OF BIRTH:** _____ **SEX:** _____

REASON FOR SEEING DOCTOR:

_____

_____

MEDICAL HISTORY: (Check only chronic symptoms or conditions)

YES	NO		If YES explain below
☐	☐	Kidney Stones	_____
☐	☐	Recurrent Urinary Infections	_____
☐	☐	Kidney, Bladder, Prostate Problem	_____
☐	☐	Genital Problem	_____
☐	☐	Sexually Transmitted Diseases, HIV	_____
☐	☐	Heart Attack, Heart Problem	_____
☐	☐	Lung Problem, Asthma, TB, Pneumonia	_____
☐	☐	Liver Problem, Jaundice, Hepatitis	_____
☐	☐	Diabetes	_____
☐	☐	High Blood Pressure	_____
☐	☐	Seizures, Stroke, Convulsions	_____
☐	☐	Bleeding Problem, Anemia	_____
☐	☐	Stomach Ulcers, Other Bowel Problem	_____
☐	☐	Emotional, Psychiatric Problem	_____
☐	☐	Chronic Headaches, Fainting	_____
☐	☐	Arthritis	_____
☐	☐	Previous Blood Transfusions	_____
☐	☐	Cancers	_____
☐	☐	Do you take any blood thinner?	_____
☐	☐	Do you take aspirin on daily basis?	_____
☐	☐	Do you have to take antibiotic prior to any Procedure?	_____

PREVIOUS SURGERIES:

☐ **YES** ☐ **NO** **If YES , Please List**

YEAR	SURGERY	YEAR	SURGERY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS:

☐ **YES** ☐ **NO** **If YES , Please List**

_____	_____	_____	_____
_____	_____	_____	
_____	_____	_____	_____

ALLERGIES:

☐ **YES** ☐ **NO** **If YES , Please List**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY: (Check if you have family history of any of the following)

YES	NO		If YES explain below
☐	☐	Prostate cancer	_____
☐	☐	Kidney, Bladder or other urological cancers	_____
☐	☐	Kidney stones	_____
☐	☐	Diabetes, Hypertension, Heart attack, Stroke,	_____
☐	☐	Other cancers	_____

PERSONAL HISTORY:

YES	NO		If YES explain below
☐	☐	Smoking:	_____ packs/day, for _____ years
☐	☐	Alcohol:	☐ Socially ☐ Frequently
☐	☐	Recreational drugs:	_____

PRE_STERILIZATION HISTORY:

☐ Married: Number of years married: _____ Wife's Age _____
☐ Divorced: Number of years divorced: _____
☐ Seperated: Number of years seperated: _____
☐ Living Together: Number of years living together: _____
☐ Never Married

Type of contraception used: _____
Age and sex of children:

Age									
Sex									

REVIEW OF SYSTEMS (Check if have any of the following):

YES	NO		If YES explain below
☐	☐	**Ears and Hearing:** Loss of hearing, Buzzing, Infections	_____
☐	☐	**Nose and Throat:** Hoarseness, Difficulty swallowing, Nose bleed, Frequent sneezing	_____
☐	☐	**Respiratory:** Shortness of breath, Wheezing, Cough	_____
☐	☐	**Cardiovascular:** Chest pain, Abnormal heartbeats, Swelling of ankle or feet, Varicose vein	_____
☐	☐	**Gastrointestinal:** Abdominal pain, Nausea-vomiting, Loss of appetite, Diarrhea, Constipation, Blood in stool	_____
☐	☐	**Genitourinary:** Problem going to bathroom, Blood in urine, Incontinence, Other urinary symptoms	_____
☐	☐	**Skin:** Itching skin, Rashes, Sores not healing	_____
☐	☐	**Musculoskeletal:** Joint pains or swelling, Difficulty walking, Back or pains in the bones	_____
☐	☐	**Neurological:** Headaches, Dizziness, Seizures, Numbness or tingling, Blackouts, Lapse of memory	_____
☐	☐	**Psychological:** Depression, Excessive stress, Hopelessness	_____

Reviewed by Dr.: _____