Fair Oaks Urology

Please Print

Name: (Last, First, Middle) ____ **Date of Birth**: ________________

Illnesses – Please list all major illnesses

Surgeries - Please list any surgical procedures

Procedure	Year	Procedure	Year

Medications – Please list **ALL CURRENT** medicines **Aspirin Y N**

Medication	How Much/How Often	Medication	How Much/How Often

Allergies – Please list all **MEDICATION** allergies

Social History

Smoking Y N I smoke(d) _____ packs/day for ______ years **OR** I quit _____ years ago.
Alcohol Y N I have _____ drinks/day **OR** I drink socially (less than 3 drinks/week)

Family Medical History **Physician use Only**

	# Answers	Level of Service
Father:	# Answers	Level of Service
Mother:	1 - 3	1 or 2
Other:	4 +	3 - 5

Review of Systems: Do you **CURRENTLY** have any problems related to the following systems? Check Y (es) or N (o).

General	Y	N	Endocrine	Y	N	Neurological	Y	N	Urological	Y	N
Fever			Too Thirsty			Tremors			Urinate Often		
Chills			Too Hot/Cold			Dizzy Spells			Painful Urination		
Headache			Tiredness			Numbness			Urinate Slowly		
						Tingling			Urinate at Night		
Allergy/Immunology			**Gastrointestinal**						Urinary Leakage		
Hay Fever			Stomach Pain			**Psychological**			Incomplete Emptying		
Drug Allergy			Nausea			Depression					
			Vomiting								
Cardiovascular			Indigestion			**Respiratory**			**Urologic Concerns**		
Chest Pain						Wheezing					
Palpitations			**Hematologic/Lymphatic**			Cough					
Hypertension			Swollen Gland			Short of Breath					
			Bleeding Problem								
Ear/Nose/Throat			**Musculoskeletal**			**Skin**					
Ear Infection			Joint Pain			Skin Rash					
Sore Throat			Neck Pain			Persistent Itch					
Sinus Problem			Back Pain								

Physicians Signature: ____ Date: ______________________