ASSOCIATED UROLOGICAL SPECIALISTS

PATIENT MEDICAL HISTORY

Name: ___________________________ DOB:_______________Date: _____________

Please check any conditions that may apply:

☐**Arthritis**

☐**Anemia**

☐**Anxiety**

☐**A-Fib**

☐**Aneurysm**

☐**Asthma**

☐**Cancer Type: _______________________**

☐**CAD/Heart Condition**

☐**Chest Pain/Angina**

☐**COPD/Emphysema**

☐**Depression**

☐**Diabetes**

☐**Diverticulitis**

☐**GERD**

☐**Glaucoma**

☐**Gout**

☐**Heart Attack/M.I.**

☐**Heart Murmur**

☐**Hepatitis**

☐**HIV**

☐**High Blood Pressure**

☐**High Cholesterol**

☐**Hypothyroidism**

☐**Irritable Bowel Syndrome**

☐**Liver Disease**

☐**Migraine**

☐**Osteoporosis**

☐**Sickle Cell**

☐**Seizures**

☐**Spine/Back Problems**

☐**Stroke**

☐**TB**

☐**Ulcers**

☐**Other____________________________**

PATIENT SURGICAL HISTORY

Name: ___________________________ DOB:_______________ Date:_____________

Please check any conditions that may apply:

☐**Appendectomy**

☐**Amputation**

☐**Angioplasty**

☐**AP Resection**

☐**AV Fistula**

☐**Back Surgery**

☐**Bladder Surgery**

☐**Cardiac Bypass**

☐**Colon Resection**

☐**Cystectomy**

☐**Gall Bladder Removal**

☐**Gastric Bypass**

☐**Hysterectomy**

☐**Heart Valve Replacement**

☐**Pacemaker**

☐**Hernia Repair**

☐**Joint Replacement**

☐**Orthopedic Surgery**

☐**Small Bowel Resection**

☐**Tonsillectomy**

☐**Other___________________________**

If you checked the any of the above conditions, please provide the following details:

Surgery	Date of Surgery	Place of Surgery