Revere Health
Urology

MRN #___________________

PATIENT NAME:____ **Today's Date**___________________

Birthdate ___________________ **Height** ______________ **Weight** ____________

Referring Doctor ____________________ None ❑

Who is your Family or Primary care doctor?

____

What are we seeing you for today?

____

Marital Status:

❑ Married ❑ Single ❑ Widowed ❑ Divorced

Do you currently smoke? ❑ Yes ❑ No

If yes, how many years? ___________

Former smoker? ❑ *Yes* ❑ *No*

Do you drink alcoholic beverages? ❑ Yes ❑ No

List all medical **ALLERGIES:**

____

Are you currently taking blood thinners?
(i.e. Coumadin, Asprin, Xeralto, Plavix)

❑ Yes ❑ No

Do you have any of the following?

❑ Diabetes ❑ Hypertention ❑ Heart Disease
❑ Lung Disease

List **MEDICATIONS** & doses you are taking:

____
____
____
____

List **past medical problems:**

____
____
____

List past surgeries:

____
____
____

List immediate family members with health problems, causes of death & relationship to you:

____
____
____

Check any of the following you currently have or have recently had:

❑ Chest Pain
❑ Palpitations
❑ Irregular Heart Beat
❑ Wheezing
❑ Short of Breath
❑ Frequent Cough
❑ Swollen Glands
❑ Blood Disorders
❑ Bleeder
❑ Intolerance to Heat or Cold
❑ Skin Problems
❑ Rash
❑ Swollen Ankle

❑ Varicose Veins
❑ Joint Pain - neck or back
❑ Sinus Problems
❑ Ear Pain
❑ Hearing Loss
❑ Eye Pain
❑ Blurry or Double Vision
❑ Tremors
❑ Numbness
❑ Dizzy/Spinning
❑ Seizures
❑ Fever
❑ Chills

❑ Sweats
❑ Weight Loss
❑ Loss of Appetite
❑ Kidney Problems
❑ Blood in Urine
❑ Incontinence of Urine
❑ Urinary Hesitancy
❑ Urinating Often at Night
❑ Daytime Urinary Frequency
❑ Painful Urination
❑ Slow Urinary Stream
❑ Erection Problems

PHYSICIAN USE ONLY

Physician/PA Signature ____________________________

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