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	❑ Varicose Veins	❑ Sweats
❑ Palpitations	❑ Joint Pain - neck or back	❑ Weight Loss
❑ Irregular Heart Beat	❑ Sinus Problems	❑ Loss of Appetite
❑ Wheezing	❑ Ear Pain	❑ Kidney Problems
❑ Short of Breath	❑ Hearing Loss	❑ Blood in Urine
❑ Frequent Cough	❑ Eye Pain	❑ Incontinence of Urine
❑ Swollen Glands	❑ Blurry or Double Vision	❑ Urinary Hesitancy
❑ Blood Disorders	❑ Tremors	❑ Urinating Often at Night
❑ Bleeder	❑ Numbness	❑ Daytime Urinary Frequency
❑ Intolerance to Heat or Cold	❑ Dizzy/Spinning	❑ Painful Urination
❑ Skin Problems	❑ Seizures	❑ Slow Urinary Stream
❑ Rash	❑ Fever	❑ Erection Problems
❑ Swollen Ankle	❑ Chills	

PHYSICIAN USE ONLY

Physician/PA Signature _____