PREMIER UROLOGY CORP.
Patient Information

*Name _____ *Age _____ *DOB _____ *Date: _____

*Current Address: Same ☐ _____

*Height _____ *Weight _____ *E- MAIL: _____ N/A☐

Urologic History: Are you experiencing any of the following:

Unexplained Weight Loss	____	Lower Extremity Weakness	____
Dry Skin	____	Rash	____
Dry Eyes	____	Difficulty Walking	____
Dry Mouth	____	Psychiatric Problems	____
Leg Swelling	____	Impaired Sex Drive	____
Shortness of Breath	____	Easy Bleeding	____
Constipation	____	Involuntary Urine Loss	____

Past Medical History: Have you ever had any of the following conditions:

High blood pressure	_____	Anemia	_____	Kidney stones	_____
Heart disease	_____	Blood Clots	_____	Erectile Dysfunction	_____
Diabetes	_____	Blood Disease	_____	Prostatitis	_____
Stroke	_____	Migraines	_____	High Cholesterol	_____
Emphysema	_____	Seizures	_____	Cancer	_____
Hypothyroid	_____	Ulcers	_____	Type	_____
Gout	_____	Acid Reflux	_____	Fibromyalgia	_____
Hematuria	_____	Hydronephrosis	_____	Hyperthyroid	_____

Family History:

Cancer _____
Diabetes _____
Leukemia_____
Heart Disease_____
High Blood Pressure_____
_____
_____
_____

List any surgeries you have had with Dates:

Surgery	*Date*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a pacemaker? _____ Defibrillator? ____ Artificial heart valve? _____

ALLERGIES:	**Type of Reaction**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IF NO CHANGES SINCE LAST VISIT PLEASE CHECK BOX ☐

Do you Smoke? _____

How much? _____

Years smoked? _____

Years quit? _____

Alcohol Use? _____

_____

PHARMACY :
Name:_____

Location:_____

Phone #:_____

List all MEDICATIONS AND DOSE you are taking, including Aspirin, Vitamins, and herbals:

_____
_____
_____
_____
_____
_____
_____
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_____
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