Date of Service: ______

COVINA VALLEY UROLOGIC MEDICAL GROUP, INC.

ADULT AND PEDIATRIC UROLOGY

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We'd like to welcome you to our office. Please take the time to fill out this form as accurately as possible so that we can appropriately address your health needs.

Last Name: ________________________________ **First Name:** ________________________________ **M.I.**_________

Date of Birth: _________________ (mm/dd/yyyy) **Referring Doctor:** ____

Race / Ethnicity:____

What is (are) the main reason(s) for your visit today? ____

____

ALLERGIES

– Are you allergic to any of the following: *(Please check all that apply)*

Lidocaine / Novocaine   Iodine / IV Contrast   Latex

– Please list ALL other allergy to medications: ____

____

- Do you have **easy tendency to bleed** or **problem with blood clotting**? (Yes / No)

CURRENT MEDICATIONS

- Are you taking any of the following: *(Please check the medication name(s))*

Aspirin   Baby Aspirin   Ecotrin   Anacin   Effient
Excedrin   Motrin   Ibuprofen   Advil
Coumadin   Plavix   Pradaxa   Warfarin

–Please list ALL other medications you are currently taking including over the counter meds:

Drug Name:	Dosage:	Frequency:

- Pharmacy Name: ____ **Phone #:** _________________________________

- Pharmacy Address or cross streets & city:____

PAST MEDICAL HISTORY

Please CHECK if you have or have had any of the following diseases or conditions:

Cardiovascular
Heart Attack
Heart Disease
Hypertension
Stroke

Endocrine/Metabolic
Diabetes

Neurological
Parkinson's Disease
Multiple Sclerosis

Respiratory
Asthma
Emphysema

Thyroid Problems

Please list any others Past Medical History:

____

____

SURGICAL HISTORY

Please list all surgeries you have had:

____

____

- **Have you had any problems with any form of anesthesia**? (Yes / No)

FAMILY HISTORY

Please Check and indicate which family member has/had any of the following:
(Mother, Father, Siblings, Grandmother, Grandfather, Uncle , Aunt)

Asthma	______________	**High Blood Pressure**	______________
Bedwetting	______________	**Kidney Cancer**	______________
Bladder Cancer	______________	**Kidney Disease**	______________
Breast Cancer	______________	**Parkinson's Disease**	______________
Diabetes	______________	**Prostate Cancer**	______________
Heart Attack	______________	**Stroke**	______________
Heart Disease	______________	**Tuberculosis**	______________

SOCIAL HISTORY: *Please provide the following information:*

- **Marital Status: Please indicate years:**

____Single ____Married ____Separated ___Divorced ___Widowed ___Life Partner ___Common Law Spouse

- **Occupation:** ____

- **Alcohol Consumption:**

_____None _____Yes Occasional/ Social # of drinks per day _______

- **Tobacco per day:**

_____None ______Yes #_______Packs/day ______ Number of years

If you previously stopped, When? ___________________________

- **Recreational Drugs:** ______None If yes, please list: ____

REVIEW OF SYSTEMS: *(Please check any and all that apply to you)*

Constitutional
Chills
Easy Bruising
Fever
Sleep Apnea

Eyes
Blurred Vision
Double Vision
Pain

Neurological
Dizzy Spells
Numbness/Tingling
Tremors

Endocrine
Excessive thirst
Tired/Sluggish
Too Hot/Cold

Gastrointestinal
Abdominal Pain
Nausea/vomiting

Cardiovascular
Chest Pain/Angina
Heart Attack
Heart Murmur
Irregular Heart Beat

Genitourinary
Burning on Urination
Urinary Frequency
Urine retention

Respiratory
Asthma
Emphysema-Bronchitis
Pneumonia
Shortness of breath
Tuberculosis

Hematological/ Lymphatic
Swollen Glands
Blood clotting problem
Bleeding Problem
Hepatitis
HIV (AIDS)
Sickle Cell

Psychologic
Anxiety
Depressed
Generally satisfied with life

Other Review of Systems: ____