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	Endocrine/Metabolic	Neurological	Respiratory
☐Heart Attack	☐Diabetes	☐Parkinson's Disease	☐Asthma
☐Heart Disease		☐Multiple Sclerosis	☐Emphysema
☐Hypertension			
☐Stroke			☐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: _____