

BERTINI/HARRIS UROLOGY

Last Name: _____ First Name: _____ MI: _____

DOB: ___/___/___ Age: _____ Today's Date: ___/___/___

Why are you here to see the Doctor? _____

Drug Allergies (List any allergies you have to any medications.) _____

What medications are you currently taking? If none, write "none". _____

Past Medical Diagnoses:

(Circle one: Y=yes, N=no, U=unknown)

Diabetes Y N U Bleed Problems Y N U Glaucoma Y N U

Heart Attack Y N U Arthritis Y N U Asthma Y N U

Stroke Y N U AIDS Y N U Emphysema Y N U

Angina/Chest Pain Y N U HIV Infection Y N U Ulcers Y N U

High blood pressure Y N U Kidney failure Y N U Colitis Y N U

Heart Failure Y N U Urinary stones Y N U Cancer Y N U

Hepatitis Y N U Bladder leakage Y N U - If Yes, what type: _____

Yellow Jaundice Y N U Voiding problems Y N U

Operations : _____ Year: _____

_____ Year: _____

_____ Year: _____

Urologic Problems: _____ Year: _____

_____ Year: _____

_____ Year: _____