Patient Name:_____ **Date of Birth:**_____ **Today's Date:**_____

IT IS VERY IMPORTANT TO BRING YOUR MEDICATION LIST TO EVERY VISIT!

1. **Please list any allergies, adverse reactions, or side effects to medications/latex/dyes/shellfish/etc and the type of reaction you have to these items:** _____
   _____
   _____

2. **List all medications (including over-the-counter) that you are currently taking:**

Name of Medication	Strength (ex: mg)	How often do you take this medication?

3. **What is your preferred pharmacy?**

   Pharmacy Name: _____ Location (Street/City):_____

4. **Have you been diagnosed with any of the following?**

Diagnosis	Yes or No	Any other medical problems:
Diabetes	Y or N	
High Blood Pressure	Y or N	
Protein in Urine	Y or N	
Blood in Urine	Y or N	
Kidney Stones	Y or N	
Cancer (if yes, what part of body?)	Y or N	
Thyroid Problems	Y or N	
Frequent Urinary Infections	Y or N	

5. **List all surgeries you have had:**

Type of Surgery	Location on Body	Year of Surgery	Surgeon or Facility

6. **Provide a Medical Family History (blood relatives only):**

Relative	Living / Deceased	Age at Death	Health Problems
Mother			
Father			
Siblings			
Children			

7. **Do or did you ever use tobacco (cigarettes, chew, vape, cigars)?** **Yes or No (circle one)**
   If yes, do you currently use tobacco? Yes or No
   If yes, how much do you use per day? _____
   If you do not currently use, when did you quit? _____
   When you used, how much did you use per day? _____

8. **Do you currently drink alcoholic beverages?** **Yes or No (circle one)**
   If yes, how much do you drink per week? _____

9. **Do you have a history or currently use substances or drugs?** **Yes or No (circle one)**
   If yes, what substances or drugs? _____

10. **Relevant History/Review of Systems:**

Do You?	Yes	No
Use of Advil, Ibuprofen, or Aleve		
Use of Herbal/Chinese Supplements		
Difficulty Urinating/Poor Stream		
Urinary Urgency, Frequency, Incontinence		
Night wakings to Urinate		
Flank Pain		
Blood in Urine/Change in Color/Foamy		
Frequent UTI's		
Leg Swelling		
Weight Gain		
Shortness of Breath		
Chest Pain/Heart Attacks/A-Fib		
Sinus Problems or Nose Bleeds		
Skin Issues/Rash		
Pregnancy related Kidney Issues		
Low Blood Count/Easy Brusing/History of Transfusions		
Recent IV Dye		

Patient Signature: **Date:**

Physician Signature: