GULF COAST UROLOGY

Patient Name: _____Date of Birth:_____

Sex: Male ___ Female ___ Age: _____ Marital Status:_____

Email Address: _____

How did you hear about us? _____

Primary Care Physician: _____Occupation: _____

Work Status: Presently working _____ Retired _____ Disabled_____

Reason for visit today: _____

Height _____ Weight_____

Do You: Smoke? No__Yes__ if yes How Long? _____ Number of Packs per day? ____

Do You: Drink Alcohol? No____ Yes____ if yes how much? _____

Preferred Pharmacy: _____

Ongoing medical illnesses (include diagnosis):

_____

_____

Prior Surgery including Month/Year:

_____

_____

Other Hospitalizations including Month/Year:

_____

_____

List current Medicines you are taking (including dosage):

_____

_____

List Allergies to Medicines and Your Reactions:

_____

Family History/Diseases: _____

_____

****Males Only****

Erectile Dysfunction No_____ Yes _____

Urinary Leakage No _____Yes _____ Number of times awakened to urinate at night: _____

****Females Only****

Urinary Leakage: No ____Yes_____ Urinary Frequency: No ____Yes____

Are you pregnant? No ____ Yes ____ # of pregnancies: _____ # of children: _____

Please check if you have now or have had in the past any of the following:

__Anemia	__Shingles	__Nerve Disorder	__Tuberculosis
__Gastritis	__Asthma	__Ulcers	__Bronchitis
__Kidney Stones	__Eye Disorder	__Blood In Urine	__Hepatitis
__Rash	__Paralysis	__HIV/AIDS	__Polio
__Anesthesia Issues	__Thyroid Condition	__Osteomylitis	__Vein Clot
__Diverticulitis	__Back Problems	__Stroke	__Cancer
__Leg/Foot Disorder	__Gout	__Bleeding Disorder	__Liver Disorders
__Rheumatic Fever	__Mental Illness	__Hypertension	__Poor Circulation
__Arthritis	__Skin Disorders	__Prostate Disorder	__Diabetes
__Emphysema	__Bladder Infections	__Venereal Disease	__Kidney Disorders
__ Leukemia	__Heart Attack	__Blood Disorders	
__Sickle Cell	__Heart Murmur	__Phlebitis	

Other Conditions: _____

This information is correct to the best of my knowledge.

_____ _____

Patient's Signature Date