COMPREHENSIVE UROLOGIC CARE, S.C.
22285 N. PEPPER RD, BLDG 200 #201, LAKE BARRINGTON, IL 60010
PHONE: 847.382.5080 FAX: 847.382.0923

Name:_____ **Date of Birth:**_____ **M** ☐ **F** ☐ **Today's Date:**_____

Primary Care MD:_____ **Referring MD:**_____

Past Medical History (Check any illnesses and tell us when they occurred).

Check this box if unknown or none apply ☐

Condition		Date	Condition		Date
Anemia	☐	_____	Heart Attack (MI)	☐	_____
Arthritis	☐	_____	Hepatitis	☐	_____
Asthma	☐	_____	Hypertension (High Blood Pressure)	☐	_____
Atrial Fibrillation	☐	_____	Hypothyroidism	☐	_____
Breast Cancer (Female)	☐	_____	Irritable Bowel Syndrome	☐	_____
Coronary Artery Disease	☐	_____	Migraines	☐	_____
COPD	☐	_____	High Cholesterol	☐	_____
Chest Pains (Angina)	☐	_____	Osteoporosis	☐	_____
Crohns	☐	_____	Paraplegia	☐	_____
Depression	☐	_____	Quadriplegia	☐	_____
Diabetes	☐	_____	Seizures	☐	_____
Diverticulosis	☐	_____	Spine Problems/Pain	☐	_____
Gout	☐	_____	Stroke/CVA	☐	_____

Other Information_____

Past Surgery (Check past surgeries and tell us when they occurred).

Check this box if unknown or none apply ☐

Condition		Date	Condition		Date
Amputation	☐	_____	Kidney/Ureter Stone (Basketing)	☐	_____
Angioplasty	☐	_____	Kidney/Ureter Stone (ESWL)	☐	_____
Appendectomy	☐	_____	Nephrectomy	☐	_____
AV Fistula	☐	_____	Orthopedic Surgery	☐	_____
Back Surgery	☐	_____	Peripheral Bypass Surgery	☐	_____
Cardiac Bypass	☐	_____	Prostate Surgery (Greenlight Laser) (male)	☐	_____
Colon Resection	☐	_____	Prostate Surgery (Microwave) (male)	☐	_____
Gall Bladder Removal	☐	_____	Prostate Surgery (TUNA) (male)	☐	_____
Gastric Bypass	☐	_____	Prostate Surgery (TURP) (male)	☐	_____
Hernia Repair	☐	_____	Radiation of Prostate (male)	☐	_____
Hysterectomy (Female)	☐	_____	Radical Prostatectomy (male)	☐	_____
Mesh Hernia Repair	☐	_____	Small Bowel Resection	☐	_____

Other Information_____

Past Urologic History (Check any illnesses and tell us when they occurred).

Check this box if unknown or none apply ☐

Condition		Date	Condition		Date
Bladder Cancer	☐	_____	Prostate Cancer (male)	☐	_____
Enlarged Prostate (BPH) (male)	☐	_____	Prostatitis (male)	☐	_____
Impotence (male)	☐	_____	Renal Insufficiency / Failure	☐	_____
Kidney Cancer	☐	_____	Urinary Incontinence	☐	_____
Kidney Cyst	☐	_____	Urinary Tract Infections (UTI)	☐	_____
Kidney Stones	☐	_____	Vasectomy (male)	☐	_____

Other Information_____

Family History: Check Box(es) for any illnesses in your immediate family.

Check this box if unknown or none apply ☐

Condition	Father	Mother	Brother	Sister	Family
Asthma	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Enlarged Prostate	☐		☐		☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Prostate Cancer	☐		☐		☐

Other Information_____

Social History

Do you smoke? Yes ☐ No ☐ How many packs/day?_____

Past Smoking? Yes ☐ No ☐

Do you Drink? Yes ☐ No ☐ How much?_____

Past Drinking? Yes ☐ No ☐ (Socially / Occasionally / Heavily / Recovering Alcoholic)

Living at? Home _____ Illicit drug use? Yes ☐ No ☐

Other Information_____

Current Medications (Please list all medications and dosage).

Check this box if unknown or none apply ☐

Medicines	Strength	Dosage	Duration	Notes
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Do you currently have any problems related to the following? Check applicable box if yes.

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight Loss

Gastrointestinal
- ☐ Abdominal
- ☐ Nausea/Vomiting
- ☐ Indigestion/Heartburn
- ☐ Loss of Appetite

Neurological
- ☐ Tremors
- ☐ Dizzy Spells
- ☐ Memory Problems
- ☐ Seizures

Eyes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Glaucoma

Endocrine
- ☐ Excessive Thirst
- ☐ Hot/Cold Intolerance
- ☐ Hot Flashes

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Irritable

Ear/Nose/Throat/Mouth
- ☐ Ear Infection
- ☐ Sore Throat
- ☐ Sinus Problems

Integumentary
- ☐ Skin Rash
- ☐ Boils
- ☐ Persistent Itch

Genitourinary
- ☐ Incontinence
- ☐ Painful Urination
- ☐ Frequent Urination

Cardiovascular
- ☐ Chest Pain
- ☐ Varicose Veins
- ☐ Palpitations/High BP

Hematologic/Lymphatic
- ☐ Abnormal Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Anemia

Reproductive (Male)
- ☐ Erection Problems
- ☐ Ejaculation Problems
- ☐ Infertility

Respiratory
- ☐ Wheezing
- ☐ Frequent Cough
- ☐ Shortness of Breath

Musculoskeletal
- ☐ Joint Pain
- ☐ Neck/Back Pain
- ☐ Bone Pain

Reproductive (Female)
- ☐ Menopause
- ☐ Vaginal Deliveries #_____
- ☐ Irregular Periods

Notes/Other:_____

_____

_____

Known Allergies? None Known ☐

- ☐ Penicillin (eg. Pen VK, Amoxicillin, Augmentin)
- ☐ Sulfa (eg. Septra, Bactrim)
- ☐ Cephalosporins (eg. Keflex, Duricef, Ceftin, Ceclor)
- ☐ Macrobid (Nitrofurantoin)
- ☐ Cipro
- ☐ Levaquin
- ☐ Tetracycline
- ☐ Latex
- ☐ Peanuts
- ☐ Shell Fish
- ☐ Iodine
- ☐ Demerol
- ☐ Morphine
- ☐ Codeine

Any Other:_____