Medical History and Social History

Associated Urologists AUOC of Orange County

Name: _____

Birth Date: _____ Date: _____/_____/_____

What is the reason for your appointment today?

Allergies To Medications:

Please list ALL MEDICATIONS you are taking (including herbal remedies and over the counter medications):

Please indicate all surgeries you have had (with approximate year of the surgery):

Aortic Aneurysm	Cataract Surgery / Eye Surgery	Heart Surgery	Heart Angioplasty Stent? Y / N
Appendix	Cholecystectomy / Gallbladder	Hernia Repair	Thyroid Surgery
Back Surgery or Neck Surgery	Colon Resection	Hip or Knee Replacement	Tonsillectomy
C-Section	Coronary Artery Bypass	Hysterectomy	Weight Loss Surgery
Mastectomy / Breast Cancer Surgery	Heart Pacemaker	Hemorrhoid Surgery	

Other Surgeries:

Circle all medical problems for which you see a doctor regularly (diabetes, hypertension, etc.):

Anxiety or Depression	Colon Cancer	Diabetes	Hypercholesterolemia/High Cholesterol
Arthritis	Congestive Heart Failure	Diverticulosis	High Blood Pressure / Hypertension
Asthma	Constipation	Fibromyalgia	Heart Disease
Breast Cancer	COPD	GERD / reflux	Peripheral Vascular Disease
Stroke / TIA	Crohn's Disease	Glaucoma	
Chest Pain / Angina	Dementia	Gout	Sleep Apnea

Other Medical Problems:

Family medical history

Prostate Cancer	Kidney Cancer	Bladder Cancer	Kidney Stones

Family History of Other Diseases:

Marital Status:

☐Married ☐Single ☐Divorced ☐Widowed ☐ Separated

Smoking Status:

☐Current every day smoker ☐Current some day smoker ☐Former smoker ☐Never smoker

Race (not mandatory, requested by government)

☐American Indian/Alaska Native ☐Black/African American ☐Hawaiian/Pacific Islander ☐White
☐Asian ☐Decline to state ☐Hispanic or Latino

Ethnicity (not mandatory, requested by government)

☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to state

Preferred language: _____

Do you have any of the following?

Fever	Chills	Weight Loss
Blurry vision	Double Vision	Cataracts
Hearing Loss	Nasal Stuffiness	Sore Throat
Chest Pains	Swollen Ankles	Irregular Heartbeat
Shortness of Breath	Wheezing	Chronic Cough
Abdominal Pain	Nausea/Vomiting	Change in Bowels
Incontinence	Painful Urination	Blood in Urine
Chronic Back Pain	Chronic Neck Pain	Sore Muscles
Rash	Persistent itching	Skin Cancer History
Numbness	Tingling	Dizziness
Swollen Glands	Abnormal Bleeding	Transfusion History

How much do you weigh? _____

What is your typical blood pressure (if known)? _____/_____

How tall are you? _____

Who is your primary care Doctor?

Name: _____

Phone number: _____

Fax number: _____

What and where is your preferred pharmacy?

Name: _____

City: _____

Phone number: _____

Fax number: _____