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# San Buenaventura Urology Center

 Community Memorial Health System

Phone: (805) 643-4067  
Fax: (805) 648-5612

First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please list previous surgeries:

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Please list all medications you are currently taking:

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Patient Label

## Urology Patient History Form

First Name: \_\_\_\_\_  
Middle Initial: \_\_\_\_\_  
Last Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

### Referred by:

Married: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_ Single: \_\_\_\_\_ Number of children: \_\_\_\_\_

### What is your main symptom(s) (problem) at present?

### Urologic History:

**Yes No**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary tract infections? _____                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney or bladder stones? _____                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in the urine? _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Pus in the urine? _____                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Protein in the urine? _____                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Sugar in the urine? _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Incontinence (loss of urine) or bedwetting? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | X-rays of kidneys? _____                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous urologic tests or procedures? _____      |
|                          |                          | Other _____                                       |

### Past Medical History (Please circle any of the following if you have/had the disease)

High blood pressure	Jaundice	Colitis
Heart disease	Kidney disease	Glaucoma
Heart attack	Bone or joint disease	Asthma or hay fever
Chest pain	Arthritis	Scarlet fever
Stroke	Rheumatism	Diphtheria
Diabetes	Cancer	Smallpox
Tuberculosis	Gout	Migraine headaches
Pneumonia	Gonorrhea or Syphilis	Hives or eczema
Rheumatic fever	Anemia	Nervous disorder
Lung disease	Epilepsy	Liver disease

### Previous injury?

### Hospitalizations?

### Pregnancy? (How many?)

### Have you had a recent cardiogram or chest x-ray?

### Habits? (Tobacco, alcohol, coffee, other)

### Family History: (any family members who have had the following diseases)

Diabetes? _____	Kidney Stones? _____
Tuberculosis? _____	Heart Disease? _____
Cancer? _____	Other _____