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:

_____

_____

_____

_____

_____

_____

Please list all medications you are currently taking:

_____

_____

_____

_____

_____

San Buenaventura Urology Center

Community Memorial Health System

Patient Label

First Name:

Middle Initial:

Last Name:

Date of Birth:

Urology Patient History Form

Referred by:

Married:____ Divorced:____ Widowed: ____ Single: ____ Number of children:____

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

Urologic History:

Yes	No		
☐	☐	Urinary tract infections?	
☐	☐	Kidney or bladder stones?	
☐	☐	Blood in the urine?	
☐	☐	Pus in the urine?	
☐	☐	Protein in the urine?	
☐	☐	Sugar in the urine?	
☐	☐	Incontinence (loss of urine) or bedwetting?	
☐	☐	X-rays of kidneys?	
☐	☐	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 _____