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:

_____

_____

_____

_____

_____

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Patient Label

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 ____