GOLDFIELDS UROLOGY – PATIENT MEDICAL HISTORY

Surname: _____ **Given Names:** _____

D.O.B. (DD/MM/YYYY) _____ **Occupation** *(previous if retired)*: _____

Reason for this urological consultation: _____

_____

Please list other medical professionals involved in your care: _____

_____

Indicate if anybody in your family has had the following cancers: Please Circle

Breast Cancer	Prostate Cancer

UROLOGICAL MEDICAL HISTORY

Do you have or ever been told you have any of the following conditions? Please Circle

Condition			
Kidney Disease	Y	N	
Kidney Stones	Y	N	

Any relevant Family History? _____

_____

ALLERGIES: YES NO Known Allergies

Please list known allergies: (eg, Medication, foods or other)

_____ _____

_____ _____

What is the type of reaction: _____

MEDICATIONS AND SUPPLEMENTS:

Please list all medications, nutritional supplements, herbs, vitamins and over the counter medications you take.

Name of Medication or Supplement	**Name of Medication or Supplement**
1.	**8.**
2.	**9.**
3.	**10.**
4.	**11.**
5.	**12.**
6.	**13.**
7.	**14.**

GENERAL MEDICAL HISTORY

Do you have *or* ever been told you have any of the following conditions? *Please Circle*

Condition	Y	N	Comments
Heart Valve Replacement	Y	N	
Heart Arrhythmias or AF	Y	N	
Have you ever had Angina?	Y	N	
Have you ever had a Coronary Stent or Heart Surgery?	Y	N	If Yes, What year?
Diabetes	Y	N	If Yes please circle: Diet / Tablets / Insulin
High Blood Pressure	Y	N	
Low Blood Pressure/ Dizziness	Y	N	
Lung/ Respiratory Problems. Eg Asthma, COPD, Emphysema	Y	N	
Liver Problems. Eg hepatits	Y	N	
Bowel Problems	Y	N	
Blood Disorders	Y	N	
Cancer	Y	N	If so what Type?
Joint Replacements. Eg Hip/knee	Y	N	
Stroke/ TIA's	Y	N	
DVT or Pulmonary Embolism	Y	N	
Sleep Apnoea	Y	N	
Have you ever had Back Surgery?	Y	N	
Urological Surgery. Eg TURP	Y	N	
Gynaecological Surgery. Eg Hysterectomy	Y	N	
Neurological Conditions. Eg Multiple Sclerosis	Y	N	
Are you on any Medications that ***thin*** your blood? Eg Warfarin, Plavix	Y	N	
Are you on any medications that decrease your immune system? Eg. Prednisolone, Chemotherapy Meds.	Y	N	
Do you currently smoke?	Y	N	If yes, How many per day?_____ For how many years?_____
Have you ever been a smoker?	Y	N	Stopped Smoking when? _____
Do you drink any alcohol?	Y	N	If yes, How many standard drinks per day?_____ or week?_____

Have you had any other serious illness/condition not listed above?_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status

Patient Signature: _____ **Date:** _____