

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Palmetto Greenville Urology, P.A.**

**General Information**

Medications you are presently taking:  
NAME/DOSAGE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(PLEASE BRING ALL OF YOUR MEDICATIONS WITH YOU EACH VISIT)**

ALLERGIES TO MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU EVER HAD X-RAYS OF THE KIDNEYS OR A CYSTOSCOPY? \_\_\_\_\_  
WHEN?(give dates) \_\_\_\_\_

	PATIENT	FAMILY HISTORY	RELATIONSHIP:
Asthma?	_____	_____	_____
Cancer (type)?	_____	_____	_____
Diabetes?	_____	_____	_____
Heart disease?	_____	_____	_____
High blood pressure?	_____	_____	_____
High Cholesterol?	_____	_____	_____
Kidney disease?	_____	_____	_____
Kidney stones?	_____	_____	_____
Thyroid?	_____	_____	_____

Do you smoke? Yes \_\_\_\_\_ Packs per day \_\_\_\_\_ Years \_\_\_\_\_  
No \_\_\_\_\_

Do you drink alcoholic beverages? Yes \_\_\_\_\_ How much per day? \_\_\_\_\_  
No \_\_\_\_\_

Are you on a special diet? \_\_\_\_\_ What kind? \_\_\_\_\_

**LIST ALL PRIOR SURGERIES AND DATES (approximate):**

\_\_\_\_\_  
\_\_\_\_\_

What brings you to the office today? \_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Address \_\_\_\_\_

Pharmacy Phone \_\_\_\_\_