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_____ No_____ Packs per day _____ Years _____

Have you ever smoked before? Yes____No____ When?_____Packs per day____Years____

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_____