

FLORIDA SPECIALISTS IN UROLOGY

NAME _____ DATE ____ / ____ / ____

AGE ____ DOB ____ / ____ / ____ REFERRING PHYSICIAN _____

LIST ALL MEDICAL AND SURGICAL HISTORY (Date of Onset)

- 1 _____ DATE _____
- 2 _____ DATE _____
- 3 _____ DATE _____
- 4 _____ DATE _____
- 5 _____ DATE _____
- 6 _____ DATE _____
- 7 _____ DATE _____
- 8 _____ DATE _____
- 9 _____ DATE _____
- 10 _____ DATE _____

CURRENT MEDICATIONS (Dosage)

ALLERGIES

- | | |
|---------|---------|
| 1 _____ | 1 _____ |
| 2 _____ | 2 _____ |
| 3 _____ | 3 _____ |
| 4 _____ | 4 _____ |
| 5 _____ | 5 _____ |
| 6 _____ | 6 _____ |
| 7 _____ | 7 _____ |
| 8 _____ | 8 _____ |

FAMILY HISTORY (List any diseases of Family Members)

- 1 _____ 2 _____
- 3 _____ 4 _____

FAMILY HISTORY OF PROSTATE CANCER NO ____ YES ____ / _____

(What relation is that Family Member to You?)

MOTHER ALIVE ____ DECEASED ____ AGE ____ FROM WHAT? _____

FATHER ALIVE ____ DECEASED ____ AGE ____ FROM WHAT? _____

SOCIAL HISTORY: TOBACCO? ____ NO ____ YES ____ HOW MUCH? _____ # OF YEARS _____

ALCOHOL? ____ NO ____ YES ____ HOW MUCH? _____ # OF YEARS _____

OCCUPATION _____

HISTORY OF PRESENT ILLNESS (For Office Use Only)
