Urology Associates of Danbury, P.C.

Patient Name: _____ DOB:_____

Height:_____ Weight:_____

Chief Complaint: What is the main reason for your visit today ? _____

ALLERGIES:			
Medications	**Dosage**	**How Often**	**Notes**

List Medical Problems: (Please list any chronic illnesses, past surgeries or hospitalizations)

□ High Blood Pressure □ Heart Problems
□ Diabetes □ Asthma
□ Heart Problems □ Glaucoma
□ Heart Murmur □ Afibrillation
□ Valve Replacement □ Coronary Disease
□ Joint Replacement

Other (Please list):_____

_____

List Hospitalizations:_____

_____

Past Surgeries:_____

_____

Social History:

Do/did you smoke: Yes No How much_____ No. of years_____ When did you stop_____

Number of Alcoholic Beverages per week_____ Occupation:_____

Family History: □ Unknown Family History

	Relation		Relation
Bladder Cancer	_____	Pancreatic Cancer	_____
Prostate Cancer	_____	Diabetes	_____
Kidney Cancer	_____	Heart Disease	_____
Breast Cancer	_____	Kidney Stone	_____
Ovarian Cancer	_____	Kidney Disease	_____

Are any members of your immediate family deceased? □ Mother □ Father □ Sister □ Brother