Medical History

Patient Name: ______________________________

DOB: ______/______/________

Current Medications: List all medications you currently take including vitamins, herbal supplements, and over the counter medications.

Medication	Dosage	Medication	Dosage

Allergies:

Preferred Pharmacy:

Name	Town	Phone #

Past Surgical History:

Type of Surgery	Year

Recent Hospitalizations:

Date	Reason	Hospital

Personal Medical History (check all that apply)

☐ Anemia	☐ Asthma, Emphysema	☐ UTI	☐ Erection Problems	☐ Prostate Cancer
☐ Cancer	☐ Bladder/Kidney Infections	☐ Hepatitis	☐ Blood Clots	☐ Kidney Stones
☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Bleeding Problems	☐ Incontinence
☐ Stroke	☐ Blood in Urine/Stool	☐ Pregnancies	☐ Urination Problems	☐ Gastrointestinal

Other Problems:

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Reason for today's visit:

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