Medical History

Gillespie County UROLOGY

Patient Name: _____

DOB: _____/_____/_____

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

Medication	Dosage	Medication	Dosage
If you need more space please list on the reverse side.			

Allergies:

HEIGHT:_____ **WEIGHT:**_____

Preferred Pharmacy:

Name	Town	Phone #

Past Surgical History:

Type of Surgery	Year
If you need more space, please list on the reverse side	

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:

_____

Reason for today's visit:

_____

_____

_____