Urology birmingham
CENTERS OF ALABAMA, P.C.®

Please fill out both sides of this form completely

Urologist: _____ Account: _____ Date: _____

Name: _____ Date of Birth: _____

The Name of your Primary Care Physician: _____

Name the Physician that referred you if different: _____

List the names of all the medicines you take including any supplements or over-the-counter drugs:
Dosage is not needed

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you Allergic to: ❑ No Known Drug Allergies

❑ Aspirin ❑ Demerol ❑ IVP Dye ❑ Levaquin ❑ Macrodantin ❑ Percocet ❑ Sulfa
❑ Cipro ❑ Erthromycin ❑ Keflex ❑ Lortab ❑ Morphine ❑ Phenergan ❑ X Ray Dye
❑ Codeine ❑ Iodine ❑ Latex ❑ Macrobid ❑ Penicillin ❑ Seafood
❑ Other: _____

Your Medical History - Please Check if you have or ever have any of the following diseases:

❑ Acid Reflux (GERD)
❑ Cancer _____ (type)
❑ Chest Pain
❑ Dementia
❑ Diabetes
❑ Endometriosis
❑ Heart Attack
❑ Heart Failure
❑ High Blood Pressure
❑ High Cholesterol
❑ Irregular Heartbeats
❑ Lung Disease / Emphysema
❑ Mitral Valve Prolapse
❑ Prior Chemotherapy
❑ Prior Radiation Treatment
❑ Spastic Colon
❑ Stroke
❑ Thyroid Disorder
❑ Ulcer
❑ NONE
❑ Other _____

Your Surgical History - Please check if you have had any of the following Surgeries:

❑ Abdominal Aneurysm
❑ Abdominal Hernia
❑ Abdominal Hysterectomy
❑ Angioplasty
❑ Appendectomy
❑ Back Surgery
❑ Bladder
❑ Breast Surgery
❑ C - Section
❑ Cataracts
❑ Cervical Disc
❑ Colon
❑ Defibrillator
❑ Gallbladder
❑ Heart By Pass
❑ Heart Stent
❑ Heart Valve
❑ Hernia (Left)
❑ Hernia (Right)
❑ Joint Surgery
❑ Kidney Stone Surgery
❑ Ovary
❑ Pacemaker
❑ Prostate
❑ Splenectomy
❑ Stomach Ulcer
❑ Tonsils
❑ Tubal Ligation
❑ Vaginal Hysterectomy
❑ None
❑ Other _____

Your Family History - Please check if your Mother, Father, Brother or Sister ever had any of the following diseases:

❑ Family History: Bladder Cancer
❑ Family History: Kidney Disease
❑ Family History: High Blood Pressure
❑ Family History: Kidney Cancer
❑ Family History: Heart Disease
❑ Family History: Diabetes
❑ Family History: Prostate Cancer

Your Social History:

❑ Divorced
❑ Married
❑ Single
❑ Widowed

Alcohol? ❑ Current - Everyday ❑ Current - Some Days ❑ Former ❑ Never Amount _____

Tobacco? ❑ Current - Everyday ❑ Current - Some Days ❑ Former ❑ Never Amount _____

(OVER)

Do you have the following symptoms or diseases?

Fever	Yes _____	No _____	Rash	Yes _____	No _____
Chills	Yes _____	No _____	New Skin Lesions	Yes _____	No _____
Double Vision	Yes _____	No _____	Memory Difficulties	Yes _____	No _____
Cataracts	Yes _____	No _____	Headaches	Yes _____	No _____
			Mini Strokes	Yes _____	No _____
Hearing Loss	Yes _____	No _____	Seizures	Yes _____	No _____
Headaches	Yes _____	No _____			
			Muscle Weakness	Yes _____	No _____
Chest Pain at Rest	Yes _____	No _____	Joint Pain	Yes _____	No _____
Chest Pain with Exercise	Yes _____	No _____			
Irregular Heart Beats	Yes _____	No _____	Hot Flashes	Yes _____	No _____
Palpitations	Yes _____	No _____	Thyroid Disorder	Yes _____	No _____
Leg Cramps with Exercise	Yes _____	No _____			
			Depression	Yes _____	No _____
Shortness of Breath	Yes _____	No _____	Schizophrenia	Yes _____	No _____
Wheezing	Yes _____	No _____	Bipolar Disorder	Yes _____	No _____
Sleep Apnea	Yes _____	No _____			
			Easy Bleeding	Yes _____	No _____
Heartburn or Indigestion	Yes _____	No _____	Easy Bruising	Yes _____	No _____
Nausea or Vomiting	Yes _____	No _____	Sickle Cell Disease or Trait	Yes _____	No _____
Change in Abdominal Girth	Yes _____	No _____	Lymph Node Enlargement	Yes _____	No _____
Diarrhea	Yes _____	No _____			
Constipation	Yes _____	No _____	Immune Deficiency	Yes _____	No _____
Blood in Stool	Yes _____	No _____	HIV	Yes _____	No _____
			Hepatitis C	Yes _____	No _____

Have you had or do you have any other illness or conditions that we did not ask about in the list above?

_____

_____

_____

_____

_____

Do Not Write Below This Line Nurse & Physician Notes

_____

_____

_____

_____

_____